STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 STANDARD SURVEY: CENSUS: 97 SAMPLE: 34 COMPLAINT INTAKE #: NJ158856, NJ158675, NJ155565 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:	F 644		6/26/23

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

Electronically Signed | 06/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 644	Continued From page 1 Based on interviews, record review, and facility policy review, it was determined that the facility failed to complete a new Pre-Admission Screening and Resident Review (PASARR) level I for 1 (Resident #11) of 3 residents reviewed for PASARRs. Specifically, the facility failed to submit an updated PASARR level I when Resident #11 was diagnosed with [redacted] and [redacted] after admission. Findings included: Review of the facility's policy, titled, "Coordination - Pre-Admission Screening and Resident Review Program," updated in January 2023, indicated, "It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal regulations." The policy indicated, "Coordination includes: a. Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. b. Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment." Further review of the policy revealed, "A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review." A review of Resident #11's "Admission Record" revealed the facility admitted the resident on	F 644	F644- Coordination of PASSAR and Assessments. Residents affected by deficient practice: The facility failed to complete a new PASSAR level 1 for 1 of 3 residents reviewed for PASSARRs. The PASSARR for Resident #11 was redone Immediately by the SW, upon being pointed out. The results remained the same thus the resident was not affected by the deficient practice. Identify those individuals who could be affected by the deficient practice: All residents that were previously in the facility and receive a new diagnosis could be affected by the deficient practice. The SW did an audit of the residents to see if there were any residents with a new diagnosis of MR & ID. What corrective action will be accomplished for those residents affected by the deficient practice: The Regional SW on 6/12/2023 reeducated the SW on the requirements of the PASSAR processing for mental disorders and individuals with intellectual disabilities. Measures or systemic changes to ensure that the deficiencies will not recur: " The SW will audit 3 random resident charts and match their diagnosis with their PASARR weekly x 4 weeks, then monthly x 3 months. " Results of audit will be reviewed at the Monthly Quality Assurance Meeting and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 644	Continued From page 2 [redacted] Per the record, on 12/30/2021, the resident received a diagnosis of [redacted] and on [redacted] a diagnosis of [redacted] not due to a [redacted] condition. Review of the significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating the resident had [redacted]. Further review of the MDS revealed Resident #11 had active diagnoses that included [redacted] and [redacted] . A review of Resident #11's care plan, with an initiation date of [redacted], revealed the resident displayed signs and symptoms of a [redacted]. Interventions directed staff to administer medications as ordered, monitor the side effects and effectiveness of the medications, and obtain a [redacted] consult as needed. A review of Resident #11's PASARR level I dated [redacted] revealed Resident #11 did not have a diagnosis of [redacted] and had a negative screening for [redacted]. Review of the resident's medical record revealed, Resident #11 had not had another PASARR level I screen completed since [redacted] During an interview on 05/18/2023 at 2:31 PM, the Social Worker (SW) stated he relied on the nursing staff to notify him if a resident had a new [redacted] diagnosis that required another PASARR level I be completed. The SW stated	F 644	Quarterly over the duration of the audit process. Date of Completion: 6/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 644	Continued From page 3 that with Resident #11's new diagnoses of [redacted] disorder and [redacted], the resident should have had another PASARR level I completed. The SW stated PASARRs should be completed accurately and timely to ensure residents received the proper level of care. During an interview on 05/19/2023 at 8:42 AM, the Director of Nursing (DON) stated she would have to check the facility's policy on whether another PASARR level I screen needed to be completed when a resident had a new [redacted] diagnosis. The DON later stated it was important to ensure it was completed because the level I screen evaluated a resident's need for further treatment or intervention. During an interview on 05/19/2023 at 11:10 AM, the Administrator stated he was not familiar with the PASARR process and was not sure if another screen needed be conducted when a resident had a new [redacted] diagnosis after admission.	F 644		
F 645 SS=D	New Jersey Administrative Code § 8:39-5.1(a) PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation	F 645		6/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 645	Continued From page 4	F 645		

performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 645	Continued From page 5 the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews, interviews, and facility policy review, the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) was accurately completed prior to admission for 2 (Resident #43 and Resident #91) of 3 residents reviewed for PASARRs. Findings included: A review of the facility policy, titled, "Coordination-Pre-Admission Screening and Resident Review program," updated January 2023, indicated, "It is the policy of the facility to assure that all residents admitted to the facility receive a Pre-Admission Screening and Resident Review, in accordance with State and Federal Regulations." The policy further indicated "The facility will coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to	F 645	F645- PASSAR Screening for MD & ID Residents affected by deficient practice: The facility failed to ensure a Preadmission Screening and Record Review (PASARR) was accurately completed prior to admission for 2 of 3 residents reviewed, Resident #43 and resident #91. The SW evaluated and comlpetes a new PASARR Level 1 for resident #43 and #91. Resident #91 is no longer in the facility. Identify those individuals who could be affected by the deficient practice: All residents admitted have the potential of being affected. What corrective action will be accomplished for those residents affected by the deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 645	Continued From page 6 avoid duplicative testing and effort." 1. A review of an "Admission record" revealed the facility admitted Resident #91 on [redacted] with diagnoses to includ [redacted]. A review of Resident #91's [redacted] Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [redacted], revealed the resident had an active diagnosis to include [redacted]. A review of Resident #91's "Preadmission Screening and Resident Review Level I Screen," date[redacted], indicated the resident did not have a known or suspected diagnosis of a [redacted]. An interview on 05/18/2023 at 2:31 PM with the Social Worker (SW) revealed the PASARR level I came from the hospital, but he was responsible for reviewing it for accuracy. The SW stated if there were any discrepancies, he would complete a new one that reflected the correct resident information. The SW reviewed Resident #91's PASARR level I dated [redacted] that was completed on admission and verified that section two did not indicate the resident's diagnosis for [redacted] or [redacted] or any [redacted] diagnosis. The SW stated it was completed incorrectly, and he should have caught that and corrected that section and submitted the correct PASARR level I for a level II determination. The SW stated it was important to ensure the PASARR level I was completed accurately to ensure residents were in the appropriate level of care and received any additional services they were potentially eligible to receive.	F 645	The Regional SW on 6/12/2023 reeducated the SW and the Admissions Director on the requirements of the PASSAR processing for [redacted] and individuals with [redacted]. The SW will audit the residents charts to identify the residents which are diagnosed with [redacted], and/or [redacted] disorders to determine if the PASARR was filled out correctly. Measures or systemic changes to ensure that the deficiencies will not recur: " The SW will audit 3 random new admission charts and match their diagnosis with their PASARR weekly x 4 weeks, then monthly x 3 months. " Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly QAPI committee over the duration of the audit process. Date of Completion: 6/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 645	Continued From page 7 An interview on 05/19/2023 at 8:34 AM with the Director of Nursing (DON) revealed that upon admission a resident's PASARR level I was completed by the hospital. However, the facility was responsible for reviewing the level I to ensure it was accurate and reflected the resident's correct diagnoses. The DON stated if the PASARR level I was inaccurate and completed prior to admission, the facility would send the level I back to the hospital to redo. The DON stated the facility would still have been responsible for reviewing it for accuracy, and it would be sent to the social work department if there were any inaccuracies. The DON stated she would have expected the Social Worker (SW) to review Resident #91's PASARR level I and correct any inaccuracies before submitting it for level II determination. An interview on 05/19/2023 at 11:19 AM with the Administrator revealed their admissions department requested the PASARR level I from the discharging hospital. Per the Administrator, if the hospital did not send one then the Social Worker would be responsible for completing the form. The Administrator stated he thought the one sent from the hospital was reviewed, but he was not sure if the SW corrected the PASARR level I if there were discrepancies. The Administrator stated he would expect that all PASARR level I screens were completed and submitted accurately. 2. A review of Resident #43's "Admission Record" indicated the facility admitted Resident #43 on [redacted] with diagnoses that included [redacted],	F 645		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 645	Continued From page 8	F 645		

[redacted]

A review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #43 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. The MDS indicated Resident #43 had active diagnoses that included [redacted]

A review of Resident #43's care plan initiated [redacted], revealed Resident #43 used antidepressant medication due to depression. Interventions directed staff to administer [redacted] medications as ordered by the physician, [redacted]s, and provide non-pharmacological interventions.

A review of Resident #43's "Pre-Admission Screening and Resident Review Level I Screen," date[redacted], revealed the screening form indicated Resident #43 did not have a diagnosis or evidence of a [redacted].

An interview on 05/18/2023 at 2:31 PM with the Social Worker (SW) revealed the PASARR level I came from the hospital, but he was responsible for reviewing it for accuracy. The SW stated if there were any discrepancies, he would complete a new one that reflected the correct resident information. The SW reviewed the Level I PASARR completed on [redacted] for Resident #43 and confirmed the diagnoses should have been included in section two of the PASARR level I screen. The SW stated it was completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 645	Continued From page 9	F 645		

incorrectly, and he should have caught that and corrected that section and submitted the correct PASARR level I for a level II determination. The SW stated it was important to ensure the PASARR level I was completed accurately to ensure residents were in the appropriate level of care and received any additional services they were potentially eligible to receive.

An interview on 05/19/2023 at 8:34 AM with the Director of Nursing (DON) revealed that upon admission a resident's PASARR level I was completed by the hospital. However, the facility was responsible for reviewing the level I to ensure it was accurate and reflected the resident's correct diagnoses. The DON stated if the PASARR level I was inaccurate and completed prior to admission, the facility would send the level I back to the hospital to redo. The DON stated the facility would still have been responsible for reviewing it for accuracy, and it would be sent to the social work department if there were any inaccuracies. The DON stated she would have expected the Social Worker (SW) to review Resident #43's PASARR level I and correct any inaccuracies before submitting it for level II determination.

An interview on 05/19/2023 at 11:19 AM with the Administrator revealed their admissions department requested the PASARR level I from the discharging hospital. Per the Administrator, if the hospital did not send one then the Social Worker would be responsible for completing the form. The Administrator stated he thought the one sent from the hospital was reviewed, but he was not sure if the SW corrected the PASARR level I if there were discrepancies. The Administrator stated he would expect that all PASARR level I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 645	Continued From page 10 screens were completed and submitted accurately. New Jersey Administrative Code § 8:39-5.1(a)	F 645		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility policy review, it was determined that the facility failed to ensure medication and treatment carts were secured while unattended for 1 of 5	F 761	F761- Label /Store Drugs and Biologicals Residents affected by deficient practice: The facility failed to ensure medication	6/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 761	Continued From page 11 medications carts and 1 of 2 treatment carts. Findings included: Review of a facility policy titled, "Storage of Medications," reviewed January 2023, revealed, "1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications." The policy continued, "6. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended." During an observation on 05/17/2023 at 5:17 AM, there was an unlocked and unattended medication cart on [redacted] hallway. During an interview on 05/17/2023 at 5:20 AM, Licensed Practical Nurse (LPN) #16 indicated the unlocked medication cart should not have been left unattended. LPN #16 indicated she was not the last one to use the cart, then walked away and left the medication cart unlocked. The surveyor opened the top drawer to the medication cart and asked LPN #16 if it was safe. LPN #16 then returned to the medication cart and locked it. During an observation on 05/17/2023 at 5:24 AM, a treatment cart that contained prescription creams was observed unlocked and unattended on the "[redacted] of [redacted] hallway. During an interview on 05/17/2023 at 5:25 AM, LPN #16 indicated all the carts needed to be	F 761	and treatment carts were secured while unattended for 1 of 5 medication carts and 1 of 2 treatment carts no resident were affected by this deficient practice. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: • LPN #16 and LPN #17 were reeducated on 5/17/23 by Infection Control Preventionist regarding the importance of keeping the medication and treatment carts and storage of medications locked and secured. • All facility Nurses re-educated on the importance of keeping the medication and treatment carts and storage of medications locked and secured by ICP and DON. The education of all existing nurse staff is immediate and will be ongoing with all new hires. Measures or systemic changes to ensure that the deficiencies will not recur: • Compliance audits of proper storage of medications and security of medication and treatment carts Initiated. • The duration of all audits will consist of a completion of three times weekly x 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 761	Continued From page 12 locked. LPN #16 indicated she had not accessed the treatment cart, and it had probably been unlocked since she came in at 12:00 AM. During an interview on 05/17/2023 at 5:50 AM, LPN #17 indicated medication and treatment carts should not be left unlocked. During an interview on 05/18/2023 at 10:50 AM, the Director of Nursing (DON) indicated unattended medication and treatment carts should be locked when not in use so no one could access them. During an interview on 05/19/2023 at 11:35 AM, the Administrator indicated he expected the medication and treatment carts to be locked if not being watched. New Jersey Administrative Code § 8:39-29.4(h)	F 761	Quality Assurance Meeting and Quarterly over the duration of the audit process. Date of Completion: 6/26/23	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		6/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 880	Continued From page 13	F 880		

reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 880	Continued From page 14 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and facility policy review, it was determined that the facility failed to ensure that hand hygiene, including glove change, was performed during [redacted] care for 2 (Resident #7 and Resident #75) of 2 residents observed for [redacted] care. Findings included: Review of a facility policy titled, "Handwashing/Hand Hygiene," dated January 2023, specified, "7. Use an alcohol-based hand rub containing at least 70% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations": "j. after contact with blood or bodily fluids; k. after handling used dressings, contaminated equipment, etc." The policy further indicated, "9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." 1. A review of an "Admission Record" indicated the facility admitted Resident #75 on [redacted]	F 880	F880- Infection Prevention & Control Residents affected by deficient practice: The facility failed to ensure that hand hygiene, including glove change, was performed during incontinence care for 2 (Resident #7 and Resident #75) of 2 residents observed for [redacted] care. Identify those individuals who could be affected by the deficient practice: All residents who require [redacted] care have the potential to be affected. The residents affected were monitored for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: • CNA #18 and CNA #13 were educated on 5/17/23 by Infection Control and Preventionist through verbal instruction and return demonstration in proper hand hygiene, including glove	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 880	Continued From page 15 with diagnoses that include [redacted]. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #75 had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident had [redacted] The MDS indicated the resident required [redacted] with toilet use and personal hygiene. Per the MDS, the resident was occasionally [redacted] and [redacted] A review of Resident #75's plan of care, initiated [redacted], revealed the resident was at risk for [redacted] related to episodes of [redacted] This care plan directed staff to provide [redacted] care as needed to prevent [redacted] During an observation of [redacted] care for Resident #75 on [redacted] 3 at 5:25 AM, Certified Nursing Assistant (CNA) #18 washed her hands and applied gloves. Resident #75's brief was minimally soiled. CNA #18 provided [redacted] care, removed the soiled brief, and then obtained and applied a [redacted] without changing gloves or performing any type of hand hygiene. CNA #18 indicated gloves should be changed after the [redacted] was removed. CNA #18 indicated she did not change her gloves. 2. A review of an "Admission Record" indicated the facility admitted Resident #7 on [redacted] with diagnoses that include [redacted]	F 880	change during [redacted] care with involvement of these residents. • All facility Nursing staff re-educated on the importance of Infection prevention and control, the importance of hand hygiene and proper performance of hand hygiene during [redacted] care by Infection Control and Preventionist. The education of all existing nurse staff is immediate and will be ongoing with all new hires. Measures or systemic changes to ensure that the deficiencies will not recur: • Observation compliance audits of proper hand hygiene during incontinence care initiated. • The duration of all audits will consist of completion three times weekly x 4 weeks then three times monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Date of Completion: 6/26/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 880	Continued From page 16	F 880		

The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [redacted], revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted] t. The MDS indicated the resident required [redacted] with toilet use and personal hygiene. Per the MDS, the resident was always [redacted] and [redacted]

A review of Resident #7's plan of care, initiated [redacted] revealed the resident was at risk for [redacted] related to the need for assistance with activities of daily living and [redacted]. This care plan directed staff to provide [redacted] care as needed to prevent [redacted]

During an observation of [redacted] care for Resident #7 on [redacted] at 5:33 AM, CNA #13 washed his hands and applied gloves. Resident #7's [redacted] f [redacted] and a [redacted]. CNA #13 provided [redacted] care, removed the [redacted], and then obtained and applied the [redacted] without changing his gloves or performing any type of hand hygiene.

During an interview on 05/17/2023 at 1:22 PM, the Infection Control Preventionist (ICP) indicated it was the facility's policy to wash hands prior to putting gloves on and to change gloves if they became soiled. The ICP indicated if gloves became soiled, hand hygiene should be performed. The ICP indicated gloves should be changed between dirty and clean tasks for infection control. When informed that staff did not change gloves during [redacted] care through applying the [redacted] the ICP stated that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315264	A. BUILDING _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 880	Continued From page 17 an infection control issue. During an interview on 05/18/2023 at 10:53 AM, the Director of Nursing (DON) indicated gloves should be changed when they became soiled and in between residents for infection control purposes. The DON indicated if gloves had been in contact with [redacted], then she would change the gloves. The DON indicated she expected that if gloves became soiled during [redacted] care, they should be changed before touching unsoiled items. During an interview on 05/19/2023 at 11:35 AM, the Administrator indicated his expectation according to the facility's policy was that if gloves were soiled, they should be changed. New Jersey Administrative Code § 8:39-19.4(a)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061529	A. BUILDING: _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 000	Initial Comments Census: 97 Sample Size: 34 TYPE OF SURVEY: Recertification and Complaint The facility is not in substantial compliance with all of 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 provisions of 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 interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 7 of 7 days shifts for the week of 04/30/2023 - 05/06/2023 and 7 of 7 days shifts for the week of 05/07/2023 - 05/13/2023. This deficient practice had the potential to affect all residents.	S 560	COMPLETE CARE AT BEY LEA S560- Mandatory Access to Care. Residents affected by deficient practice: The facility failed to comply with applicable Federal, State, and local laws, rules, and regulations by not ensuring staffing ratios were met. No residents were identified to be affected by this deficient practice.	6/26/23

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

Electronically Signed | 06/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061529	A. BUILDING: _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aide 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 certified nurse aides, and each direct staff member shall be signed in to 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 certified nurse aide and perform certified nurse aide duties. 1. A review of the "Nurse Staffing Report," completed by the facility for the week of 04/30/2023 - 05/06/2023 revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: - 04/30/2023 had 6 CNAs for 98 residents on the	S 560	Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: The Administrator, Director of Nursing, and Staffing Coordinator were re-educated on the minimum staffing requirements. The facility has contracted with multiple staffing agencies to supplement their staff for the missing shifts in an effort to meet the staffing ratios. Measures or systemic changes to ensure that the deficiencies will not recur: Th Administartor or the designee will review daily the staffing sheet to ensure minimum requirments are being met. " The administrator/designee will participate in a weekly call for 3 months with a recruitment team to review open positions and recruitment tactics to improve hiring outcomes to meet the required staffing ratio. " The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for three months and then quarterly. " Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Date of Completion: 6/26/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061529	A. BUILDING: _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 2	S 560		

day shift, required 12 CNAs.
-05/01/2023 had 8 CNAs for 95 residents on the day shift, required 12 CNAs.
-05/02/2023 had 8 CNAs for 94 residents on the day shift, required 12 CNAs.
-05/03/2023 had 9 CNAs for 94 residents on the day shift, required 12 CNAs.
-05/04/2023 had 9 CNAs for 94 residents on the day shift, required 12 CNAs.
-05/05/2023 had 8 CNAs for 94 residents on the day shift, required 12 CNAs.
-05/06/2023 had 7 CNAs for 95 residents on the day shift, required 12 CNAs.

2. A review of the "Nurse Staffing Report," completed by the facility for the week of 05/07/2023 - 05/13/2023 revealed staff-to-resident ratios that did not meet the minimum requirements. The facility was deficient in CNA staffing for resident on 7 of 7 day shifts as follows:

-05/07/2023 had 8 CNAs for 95 residents on the day shift, required 12 CNAs.
-05/08/2023 had 7 CNAs for 93 residents on the day shift, required 12 CNAs.
-05/09/2023 had 8 CNAs for 93 residents on the day shift, required 12 CNAs.
-05/10/2023 had 9 CNAs for 93 residents on the day shift, required 12 CNAs.
-05/11/2023 had 8 CNAs for 93 residents on the day shift, required 12 CNAs.
-05/12/2023 had 7 CNAs for 94 residents on the day shift, required 12 CNAs.
-05/13/2023 had 8 CNAs for 94 residents on the day shift, required 12 CNAs.

An interview on 05/18/2023 at 2:56 PM with the Staffing Coordinator revealed she was responsible for doing the nursing staff schedules.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061529	A. BUILDING: _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 3	S 560		

The Staffing Coordinator stated she felt like it was a common theme for facilities to be shorter staffed and that she did not feel their staffing was as bad as some of the other facilities. The Staffing Coordinator stated the facility was actively trying to recruit staff. She stated they had lawn signs made and they were going into licensed nursing and certified nursing assistant schools during their open house. She also stated they were offering hours to certified nursing assistant students' hours to complete for their certification requirements. The staffing coordinator stated they tried to keep the rates competitive and offered different incentives to current staff to work overtime or additional shifts. The Staffing Coordinator stated she was aware of what the New Jersey state staffing ratios were, and she did her best to try and always meet them. The Staffing Coordinator stated there were days when staff called out right before the start of a shift, and weekends had a lot more call outs. She stated that now all new hires had to sign the facility's call out policy and were required to make up any shifts they called out for at the staff's discretion. She stated the facility lost two of their fulltime CNA staff right before the end of April. The Staffing Coordinator reviewed the schedule for the review period and stated she was aware the facility did not meet the ratios.

An interview on 05/19/2023 at 10:48 AM with the Director of Nursing (DON) revealed she knew there was regulation regarding staffing ratios, but she was not sure of what they were specifically. The DON said she was aware there had been an issue trying to meet them, but the facility was doing everything they could and were using several staffing agencies. The DON said they were also trying to retain their current staff by offering many different employee engagement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061529	A. BUILDING: _____ B. WING _____	C 05/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

(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 4 and appreciation opportunities and they had a recruiter from corporate that was actively trying to recruit. The DON said they were going into the local vocational schools for licensed practical nursing and certified nursing assistant students, and they did everything to get their name out there. An interview on 05/19/2023 at 11:10 AM with the Administrator revealed they were actively trying to retain current staff by boosting morale by offering incentives and celebrating different occasions. He stated that had helped, but they did lose some certified nursing assistant staff. The Administrator stated they had a corporate recruiter, and the facility was very active and involved in trying to recruit new staff. He stated staff responded to every employment application the facility received. The Administrator said they were going into the local vocational schools for licensed practical nursing and certified nursing assistant students and would have a job fair at the beginning of June 2023 and an open house. They also tried to keep their pay rates competitive. The Administrator stated he was aware they had been short trying to meet the staffing ratios, but the facility was trying to do everything they could.	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
315264 Y1	A. Building B. Wing Y2	7/10/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

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 F0644	Correction	ID Prefix F0645	Correction	ID Prefix F0761	Correction
Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.20(k)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	06/26/2023	LSC	06/26/2023	LSC	06/26/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/26/2023	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	
5/21/2023	☐ 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 (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061529	A. Building B. Wing	7/10/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	1351 OLD FREEHOLD ROAD TOMS RIVER, NJ 08753

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 06/26/2023	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
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	ID Prefix Reg. # LSC	Correction Completed
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 5/21/2023	☐ 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
	315264	A. BUILDING **01** B. WING _____	**05/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BEY LEA, LLC	**1351 OLD FREEHOLD ROAD** **TOMS RIVER, NJ 08753**

(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 This facility is in substantial compliance with Appendix Z - Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/21/2023 and Complete Care at Bay Lea was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. Complete Care at Bay Lea is a one-story Type III unprotected, ordinary building that was built in 1988. The facility is divided into 11 smoke zones.	K 000		

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

Electronically Signed | 06/13/2023

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.