STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315274	A. BUILDING _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LAURELTON, LLC	**475 JACK MARTIN BLVD BRICK, NJ 08724**

(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 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00149749, NJ00158244, NJ00159114, NJ00159548, NJ00160165, NJ00162593, NJ00164070 and NJ00166914 Survey Dates: 11/07/23 to 11/09/23 Survey Census: 100 Sample Size: 6 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 | 11/22/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061532	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LAURELTON, LLC	475 JACK MARTIN BLVD BRICK, NJ 08724

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S 000	Initial Comments Complaint #: NJ00149749, NJ00158244, NJ00159114, NJ00159548, NJ00160165, NJ00162593, NJ00164070 and NJ00166914 Survey Dates: 11/07/23 to 11/09/23 Survey Census: 100 Sample Size: 6 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 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: Complaint #: NJ00149749, NJ00158244, NJ00159114, NJ00159548, NJ00160165, NJ00162593, NJ00164070 and NJ00166914 Based on review of pertinent facility documentation, it was determined that the facility	S 560	S 560- 8:39- 5.1(a) Mandatory Access to Care 1. The facility leadership team has met on an ongoing basis and continues to identify staffing challenges and areas of improvement for licensed and certified	12/22/23

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

Electronically Signed | 11/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061532	A. BUILDING: _____ B. WING _____	C 11/09/2023

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COMPLETE CARE AT LAURELTON, LLC	475 JACK MARTIN BLVD BRICK, NJ 08724

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S 560	Continued From page 1 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 17 of 28 day shifts as follows: 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. As per the "Nurse Staffing Report" completed by the facility for the 4 weeks of staffing from 08/20/2023 to 09/02/2023 and 10/22/2023 to 11/04/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below:	S 560	needs. Recruitment efforts include competitive hiring rates, online advertisements, local community advertisements, market competitive sign on bonus, refer a friend bonus for current employees, onsite and on the spot interview availability, and continued use of agency staff to supplement. The center also utilizes the assistance of nurse management, physical therapist and occupational therapists to assist with direct care as directed by the Director of Nursing. 2. All residents have the potential to be affected. 3. The facility has implemented a significantly above market rate for certified nursing aides including a sign-on bonus when appropriate. The facility continues to utilize online recruitment and job fairs with immediate interviews and contingency offers. The facility implemented an expediated but robust onboarding process. The facility will use agency staff as needed to meet current and future staffing needs. 4. The Director of Nursing or Designee will meet with the staffing coordinator daily to review call outs if any, facility census vs. staffing needs. The Director of Nursing or Designee will monitor call outs and staffing ratios weekly until the requirement is met. Audits will be conducted 3x weekly for 1 month and 5 x monthly for 2 months. The results of the audit will be forwarded to the Administrator who will report the results will be sent to the QAPI committee monthly for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061532	A. BUILDING: _____ B. WING _____	C 11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LAURELTON, LLC	475 JACK MARTIN BLVD BRICK, NJ 08724

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S 560	Continued From page 2 1. For the 2 weeks of staffing from 08/20/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -08/20/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/21/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/22/23 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/23/23 had 10 CNAs for 106 residents on the day shift, required at least 13 CNAs. -08/25/23 had 11 CNAs for 109 residents on the day shift, required at least 14 CNAs. -08/26/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/27/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/29/23 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -08/30/23 had 13 CNAs for 109 residents on the day shift, required at least 14 CNAs. -09/01/23 had 10 CNAs for 103 residents on the day shift, required at least 13 CNAs. -09/02/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. 2. For the 2 weeks of staffing prior to survey from 10/22/2023 to 11/04/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -10/26/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/28/23 had 12 CNAs for 103 residents on the day shift, required at least 13 CNAs. -10/29/23 had 11 CNAs for 102 residents on the	S 560	AUdit Tool in Attachments	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 day shift, required at least 13 CNAs. -11/01/23 had 11 CNAs for 101 residents on the day shift, required at least 13 CNAs. -11/03/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -11/04/23 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061532		12/22/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LAURELTON, LLC	475 JACK MARTIN BLVD BRICK, NJ 08724

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 12/22/2023	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
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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	
11/9/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO