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 _____	10/19/2021

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 Survey Date: 10/19/21 Census: 114 Sample: 23 +3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		12/3/21

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

Electronically Signed | 11/06/2021

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 _____	10/19/2021

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 755	Continued From page 1 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to: a.) ensure the accountability of the Narcotic Shift Count logs were completed in accordance with facility policy and b.) accurately account for and document the administration of controlled medications. This deficient practice was identified on five of five medication carts and 2 of 3 medication carts reviewed for medication storage (Unit [redacted]). This deficient practice was evidenced by the following: 1. On 10/14/21 at 10:19 AM, the surveyor in the presence of the Licensed Practical Nurse (LPN #1), reviewed the nursing Unit [redacted]s October 2021 Narcotic Shift Count log which revealed the following: 10/1/21 11 PM - 7 AM shift; 10/3/21 3 PM - 11 PM shift; and 10/6/21 3 PM - 11 PM shift "Is the count correct" column was blank. 10/13/21 7 AM - 3 PM shift, the column for correct count and the nurse's signature for going off duty was blank. 10/14/21 11 PM - 7 AM, going off duty nurse signature was blank At this time, the surveyor interviewed LPN #1 who stated that both the incoming and outgoing	F 755	F-755 Pharmacy Services/Procedures/Pharmacist/Records Residents affected by deficient practice: No residents were affected by this deficient practice. The deficient practice was identified that the facility failed to accurately document the administration of a controlled substance medications for residents and sign narcotic count log. All Licensed staff was educated by the DON prior to survey exit on the facility policy and procedure on Controlled Substances and Documentation of Medication Administration. Identifying other Residents who could be affected by the deficient practice: All residents have the potential to be affected. Measures or systemic changes to ensure	

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 _____	10/19/2021

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 755	Continued From page 2 nurses on the shift performed a narcotic count together; then completed and signed the Narcotic Shift Count together in their designated area to verify the count. On 10/14/21 at 10:35 AM, the surveyor reviewed the October 2021 Narcotic Shift Count logs for all three nursing units' medication carts which revealed the following: Unit [redacted] medication cart: 10/14/21 3 PM - 11 PM shift, was pre-signed by the going off duty nurse. Unit [redacted] medication cart: 10/13/21 7 AM - 3 PM shift, the number (#) of count sheets was blank. 10/13/21 3 PM - 11 PM shift, is the count correct, # of count sheets, and nurse's signature coming on duty was blank. 10/14/21 11 PM - 7 AM and 7 AM - 3 PM shifts, were completely blank. Unit [redacted] medication cart: 10/1/21 7 AM - 3 PM and 10/2/21 11 PM - 7 AM, shifts is count correct were blank. On Unit [redacted] medication cart: 10/7/21 11 PM - 7 AM shift, is count correct was blank. On 10/14/21 at 11:23 AM, the surveyor interviewed the Director of Nursing (DON), who confirmed that both nurses had to complete and sign the Narcotic Shift Count logs together because they were both verifying the count as indicated by the facility policy. A review of the facility's "Controlled Substances"	F 755	that the deficiencies will not recur: All Licensed staff educated by DON/Infection Preventionist/Designee on the facility policy and procedure on Controlled Substances and Documentation of Medication Administration. Monitoring the continued effectiveness of the systemic change: The DON/Infection Preventionist/Designee will conduct audits of all licensed staff on Medication Pass and The removal of a controlled substances procedure, signature narcotic log, Documentation of Medication Administration, Weekly X 4 weeks then 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.	

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 _____	10/19/2021

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 755	Continued From page 3	F 755		

policy dated updated 3/2021 included that nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.

2. On 10/14/21 at 11:42 AM, the surveyor in the presence of LPN #2 conducted a narcotic count on the nursing Unit [redacted] side medication cart and observed the following:

A review of Resident #6's Individual Patient Controlled Substance Administration Record for [redacted] milligram (mg) tablet [redacted] medication) dated received [redacted] 1, reflected that out of the 60 tablets delivered, 27 tablets remained. Under the balance of 49 row, dated administered on [redacted] at 6:00 PM, the nurse who administered the medication did not sign.

A review of Resident #15's Individual Patient Controlled Substance Administration for [redacted] mg tablet [redacted] medication) dated received [redacted], reflected that out of 60 tablets delivered, 16 tablets remained. Under the balance of 32 row, dated administered on [redacted] at 6:00 PM, the nurse who administered the medication did not sign.

On 10/14/21 at 12:27 PM, the surveyor in the presence of LPN #3 conducted a narcotic medication review of the nursing Unit [redacted] high side medication cart which revealed the following:

A review of Resident #360's Individual Patient Controlled Substance Administration Record for [redacted] mg tablets dated received

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 _____	10/19/2021

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 755	Continued From page 4 [redacted], reflected that out of the 60 tablets delivered, 58 tablets remained. A physical inventory count revealed that there were 57 [redacted] tablets remaining. At this time, LPN #3 stated that the missing dose was administered to the resident earlier that morning but was not properly signed out on the controlled substance administration record. The LPN stated that at the time the medication was removed from inventory, she should have signed the administration record. On 10/15/21 at 9:20 AM, the surveyor interviewed the DON regarding the process for count inaccuracies. The DON responded that in the event of an inaccurate narcotic count, the nurse and unit manager reconciled to see if there was a medication that was administered and not signed for. The nurses were also expected to inform the DON immediately. On 10/19/21 at 10:19 AM, the DON in the presence of the Licensed Nursing Home Administrator, Administrator in training and survey team confirmed that all three controlled medications were administered, but the controlled substance administration records were not completed accordingly. A review of the facility's "Controlled Substances" policy dated updated 3/2021, included that an individual resident controlled substance record must be made for each resident receiving a controlled substance and will include the signature of the nurse administering the medication. A further review of the policy included that the Director of Nursing Services shall investigate any discrepancies in narcotics	F 755		

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 _____	10/19/2021

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 755	Continued From page 5 reconciliation to determine the cause and identify any responsibility parties and shall give the Administrator a written report of such findings. NJAC 8:39-29.7(c)	F 755		
F 761 SS=F	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 observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) properly	F 761	F-761 Labels/Store Drugs and Biologicals	12/3/21

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 _____	10/19/2021

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 761	Continued From page 6 store medications, b.) maintain clean and sanitary medication storage areas, and c.) properly label opened multidose medications. This deficient practice was observed in 3 of 3 medication carts on 3 of 3 nursing units and 1 of 2 medication storage rooms reviewed for medication storage and was evidenced by the following: On 10/14/21 at 9:51 AM, the surveyor in the presence of Licensed Practical Nurse (LPN #1) observed nursing Unit [redacted] medication cart which contained a total of 16 loose medication pills of various colors and sizes in the bottom of the drawers. LPN #1 collected these pills as they were discovered, counted, and were disposed of using the medication cart drug buster bottle. At this time, LPN #1 informed the surveyor that medication carts were cleaned monthly by housekeeping and that the nurses assigned to each cart ensured medication pills were not loose in the drawers. LPN #1 further stated that she checked for loose pills a couple days out of the week. On 10/14/21 at 11:42 AM, the surveyor in the presence of LPN #2 observed nursing Unit [redacted] high side medication cart which contained a total of [redacted] loose medication pills of various colors and sizes in the bottom of the drawers. LPN #2 collected these pills as they were discovered, counted them, and disposed of these medications using the medication cart drug buster bottle. At this time, LPN #2 stated that the nurses checked the medication carts for loose medications every shift and during medication pass and they were expected to dispose of loose medication pills in the drug buster. LPN #2 further stated that housekeeping keeps a schedule for medication cart cleaning which was posted at the nurses'	F 761	Residents affected by deficient practice: No resident was affected by this deficient practice. The deficient practice identified that the facility failed to accurately store medications and biologicals drugs. All Licensed staff was educated by the DON/ Designee prior to survey exit on the facility policy and procedure on Storage of Medications. Identifying other Residents who could be affected by the deficient practice: All residents have the potential to be affected. Measures or systemic changes to ensure that the deficiencies will not recur: All Licensed staff educated by DON/Infection Preventionist/Designee on the facility policy and procedure on Storage of Medications and biological drugs. Monitoring the continued effectiveness of the systemic change: The DON/Infection Preventionist/Designee will conduct random audits of all licensed staff on Medication Pass and The removal of medications and proper storage, Weekly X 4 weeks then monthly x 3 months. Results of audit will be reviewed at the	

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 _____	10/19/2021

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 761	Continued From page 7 station. Nurses were given a new medication cart which they transferred all medication into while housekeeping performed the monthly cart cleaning. On 10/14/21 at 12:27 PM, the surveyor in the presence of LPN #3 observed nursing Unit [redacted] medication cart which contained a total of six (6) loose medication pills of various colors and sizes in the bottom of the drawers. LPN #3 collected these medication pills as they were discovered, counted, and disposed of using the medication cart drug buster bottle. At this time, LPN #3 stated that with multiple nurses using these carts and the crowding of medication in the carts, medication can pop out of the bingo cards. LPN #3 further stated that, "the only thing we do is check the narc (narcotic) box" and checking for loose pills in the cart was "not what we do." On 10/15/21 at 9:42 AM, the surveyor in the presence of LPN #4 observed nursing Unit [redacted] medication storage room. In the medication refrigerator they observed: one opened box of [redacted] (an injectable medication used to [redacted]) dated [redacted], which contained two opened vials. One vial was dated [redacted] and the second opened vial was not dated. When the surveyor asked LPN #4 how long this medication was good for once opened, the LPN stated, "90 days, I think." At this time, the LPN took this box of medication along with the two opened vials it contained to the LPN/Unit Manager (UM) and the Licensed Nursing Home Administrator (LNHA). The LPN/UM acknowledged that this vial should have been dated once opened, and that it was good for 30 days once opened. The LPN/UM stated that since they were unsure of when this vial was	F 761	Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.	

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 _____	10/19/2021

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 761	Continued From page 8 opened, it would be thrown out. On 10/15/21 at 9:00 AM, LPN #2 provided the surveyor with a copy of the housekeeping October 2021 medication cart cleaning schedule titled "Nursing Cart Carbolization Schedule" which indicated that Unit [redacted] side medication cart was signed carbolized on [redacted] and Unit [redacted] high side medication cart was scheduled to be carbolized on [redacted] On 10/19/21 at 10:19 AM, the Director of Nursing (DON) in the presence of the LNHA, Administrator in training, and survey team, acknowledged these findings. A review of the facility's "Storage of Medications" policy dated updated 1/2021, included that drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. The policy also included that nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. A review of the undated Consultant Pharmacy Provider's "Expiration Dates for Opened Medications" list provided by the DON, included that tuberculin purified protein derivative was to be refrigerated at all times and discarded 30 days after first use.	F 761		
F 812 SS=D	N.J.A.C. 8:39-29.4 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		12/3/21

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 _____	10/19/2021

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 812	Continued From page 9 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner designed to prevent foodborne illness. This deficient practice was evidenced by the following: On 10/12/21 at 9:42 AM, the surveyor toured the kitchen with the Food Service Manager (FSM) and observed the following: In the milk walk-in refrigerator 1. One opened nine-pound container of feta cheese labeled received [redacted] There was no date when the feta cheese was opened or when to use by. The FSM stated that the cheese should be used within seven days of opening and	F 812	F812: SCOPE and SEVERITY = D FOOD PROCUREMENT, STORE/PREPAR/SERVE-SANITARY CFR(S) 483.60(i)(1)(2) CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The following corrective actions were immediately implemented: ¿ The container of feta cheese, the chocolate cake, the cottage cheese containers, the blueberry muffin batter, and the container of peeled hard boiled eggs with incorrect labeling and dating, were immediately removed from the milk walk-in fridge and discarded.	

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 _____	10/19/2021

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 812	Continued From page 10 discarded. 2. One chocolate cake labeled and dated 10/6/21 and 10/8/21. The FSM stated that the chocolate cake should have been discarded on 10/8/21. 3. One five-pound opened cottage cheese container. The container had a printed use by date of 9/4/21. 4. Four five-pound unopened cottage cheese containers with a use by date of 9/4/21. 5. One opened container of blueberry muffin batter. The container had no received, opened, or use by date. 6. One container of peeled hard-boiled eggs labeled delivered on 9/8/21. There was no labeled opened date or use by date. The FSM stated that she was unsure how many days the eggs were good for after opened but would find out that information. On 10/12/21 at 10:01 AM, the surveyor observed a large bin of breadcrumbs outside the dry storage area. The bin contained a scoop directly in the breadcrumbs. The FSM confirmed that the scoop should not be stored directly in the food. On 10/12/21 at 10:03 AM, the surveyor and the FSM observed in the dry storage area the following: 1. Three 111-ounce (oz) cans of three bean salad, the cans were dented. 2. Three 107-oz cans of crushed pineapple, the cans were dented.	F 812	¿ The scoop that was found resting directly in the breadcrumbs was removed from the large bin of breadcrumbs, and properly placed on the side of the bin. ¿ The dented cans in the Dry Storage Room were immediately removed so that they will not be used. ¿ No residents were affected by the deficient practice. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by the same deficient practice. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR All Dietary Staff were in-serviced on the regulations and facility□s policies on the following: ¿ Dating and Labeling Policy ¿ Receivable and Storage Policy ¿ Dented Can Policy MONITORING OF CORRECTIVE ACTIONS ¿ Dietary Account Manager or designee will conduct Kitchen Observation Audits weekly x 1 month; then thereafter monthly x 6 months. Emphasis will be made on	

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 _____	10/19/2021

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 812	Continued From page 11 3. One 106-oz can of diced peaches, the cans were dented. On 10/13/21 at 11:23 AM, the surveyor interviewed the FSM who stated that the feta cheese and cottage cheese should be discarded after seven days of being opened and that the hard-boiled eggs should be used within one week. On 10/19/21 at 10:11 AM, the Licensed Nursing Home Administrator, in the presence of the facility's administration and survey team, acknowledged the surveyor's findings. A review of the facility's undated "Dating and Labeling Policy" included to: label products in storage with date package was opened; ready to eat foods must be dated with a seventy-two hour use by date or discarded when expired; label all goods with date received; and discard all foods that expire immediately. A review of the facility's undated "Receivable and Storage Policy" included to: ensure that all foods are securely covered, dated, and labeled. A review of the facility's undated "Dented Can Policy", included in the procedure to: identify all unacceptable dented cans; upon discovery use a black marker to label can with current date and vendor's name; and place all dented cans on a designated shelf marked "Dented Cans". NJAC 8:39-17.2(g)	F 812	proper Dating and Labeling, handling and storage of foods and Equipment. Any issues identified in the audits will be rectified immediately. ¿ Audit Findings will be reported to the QAPI Committee on a monthly basis. The QAPI Committee will determine the need for further audits and or action plans on a quarterly basis ensuring on-going compliance.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061532 Y1	A. Building B. Wing Y2	1/6/2022 Y3

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 01/03/2022	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	
10/19/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315274	A. Building B. Wing	1/6/2022

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 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 F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 12/03/2021	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 12/03/2021	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 12/03/2021
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
10/19/2021

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