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 02/09/2024

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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E 000	Initial Comments This facility is not 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		
E 004 SS=D	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the	E 004		2/21/24

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

Electronically Signed | 02/21/2024

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E 004	Continued From page 1 requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Plan and Program (EPP), it was determined that the facility failed to ensure that the Emergency Preparedness Plan was maintained, reviewed, and updated at least annually. This deficient practice was evidenced by the following: On 02/01/2024 at 11:48 AM, the surveyor reviewed the Unit 3 nurses station Emergency Preparedness Plan (EPP) manual. Review of the EPP revealed that it was last updated on 03/24/2022. The "Emergency Contact List" indicated a date of 03/24/2022. This contact page listed an incorrect Administrator with his phone number and email address; incorrect US FOIA (b) (6) with her phone number and email address; and incorrect US FOIA (b) (6) with her phone number and email address. The current administrator, US FOIA (b) and US FOIA (b) (6) and their contact information were not listed.	E 004	Residents affected by deficient practice: " The facility failed to ensure that the Emergency Preparedness Plan was maintained, reviewed, and updated at least annually. 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: " The facility□s Emergency Preparedness Plan has been updated to include documentation for all deficiencies cited. " An Updated copy of the Emergency Preparedness Plan was distributed to each nursing station and the receptionist desk.	

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E 004	Continued From page 2 On 02/01/2024 at 11:53 AM, the surveyor went to the Unit 2 nurses' station and was not able to locate the EPP manual. The US FOIA (b) (6) retrieved the binder from an office for the surveyor. The EPP manual did not contain any Emergency Preparedness Plan. The manual was empty. The US FOIA (b) (6) stated, "The binder is empty, but it should have the EPP in it." On 02/01/2024 at 11:58 AM, the surveyor reviewed the Unit 1 nurses' station EPP manual. Review of the EPP revealed that it was last updated on 03/24/2022. The "Emergency Contact List" indicated a date of 03/24/2022. This contact page listed previous Administrator with his phone number and email address; previous US FOIA (b) (6) with her phone number and email address; and previous US FOIA (b) (6) with her phone number and email address. The current Administrator, US FOIA (b) and US FOIA (b) (6) and their contact information were not listed. On 02/02/2024 at 10 AM, the surveyor reviewed the EPP manual that is located at the receptionist desk in the facility lobby. The EPP revealed that it was updated 12/19/2023. The "Emergency Contact List" indicated a date of 12/19/2023. This contact page listed the current Administrator, US FOIA (b), and US FOIA (b) (6) with their phone numbers and email address. On 2/02/2024 at 11:05 AM the surveyor conducted an interview with the facility US FOIA (b)(6). The US FOIA (b)(6) stated that, "There should be EPP manuals located at each unit's nurses' station." The US FOIA (b)(6) then stated, "They should be updated annually."	E 004	" The US FOIA (b)(6) were educated by the Regional Administrator on 2/19/2024 on the requirement of updating the Emergency Preparedness Plan at least annually and ensuring it is available in the building as required. Measures or systemic changes to ensure that the deficiencies will not recur: " Facility staff were re-educated on the contents and locations of the Emergency Preparedness Plan. " Administrator/designee to conduct compliance audits to ensure that the Emergency Preparedness Plan is at the required locations. " The duration of all audits will consist of completion one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. " Residents will be protected in event of an emergency due to the, education, audits and updated binders in all required areas.	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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E 004	Continued From page 3 A review of the provided facility Emergency Preparedness Plan with an updated date of 12/19/2023 revealed on page 6 under section "Promulgation Statement by Administrator". "Copies of this Emergency Preparedness Plan shall be provided and/or made available to all those named in the distribution list." Review of the "Distribution List" revealed that "This document shall be located and always available at the reception desk and all nurse stations." NJAC 8:39-31.6	E 004		
F 000	INITIAL COMMENTS Complaint #s: 163428, 166005, 166077, 166569, 169841 Survey Date:02/06/24 Census: 102 Sample Size: 25 + 19 = 44 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. THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 610 SS=G	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		2/21/24

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F 610	Continued From page 4 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review it was determined that the facility failed to ensure that a complete and thorough investigation was conducted for Resident # 257 who sustained a [redacted] of NJ Exec Order 26.4b1 of the [redacted]. Resident # 257 required an [redacted] and NJ Exec Order 26.4b1 of the [redacted] on [redacted]. This deficient practice was identified for 1 of 1 Resident (Resident #257) reviewed for [redacted] of NJ Exec Order 26.4b1 was evidenced by the following: Refer to 684G On 02/02/24 at 9:58 AM the surveyor, in the presence of the survey team, interviewed the US FOIA (b) (6) regarding reportable events and the Quality Assurance and Performance Improvement process. The surveyor inquired about any recent significant	F 610	Residents affected by deficient practice: " The facility failed to ensure that a complete and thorough investigation was conducted for Resident # 257 who NJ Exec Order 26.4b1 of the [redacted] Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. " The affected resident # 257 no longer resides in the facility. " Director of Nursing reviewed all reportable events/significant occurrences to ensure that all required documentation is included based on the Accidents and Incident-Investigation and Reporting policy.	

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F 610	Continued From page 5 events and the US FOIA (b) informed the surveyor about Resident #257 who sustained a NJ Exec Order 26 of NJ Exec Order 26.4b1. The surveyor inquired further about what was completed regarding the incident, and the US FOIA (b stated the resident NJ Exec Order 26.4b1 and "I just did an investigation" and then provided the surveyor with a copy of a Reportable Event (a required document to be submitted to the Department of Health). Review of the documents attached to the Reportable Event (RE) included a titled, "Investigational Summary and Conclusion", one page of a Care Plan, and copies of fax transmissions dated NJ Exec Order 26.4b, to the Department of Health and Ombudsman's office. There were no witness statements or documented interviews provided. The surveyor asked if there was a root cause analysis completed regarding the NJ Exec Order 26 and the US FOIA (b) stated, "no, that is QAPI (Quality Assurance and Performance Improvement)." The surveyor requested the complete investigation for Resident #257's NJ Exec Order 26.4b1. A review of the RE dated NJ Exec Order 26.4b and Person Reporting: US FOIA (b) (6) revealed: Date of Event: NJ Exec Order 26.4b and Time of Event: 9:42 PM; Was NJ Exec Order 26.4b1 ". The Type of Incident: "NJ Exec Order 2 Narrative- "Resident was admitted on NJ Exec Order 26.4b1 at home. On admission resident c/o [complained of] NJ Exec Order 26.4b1, with NJ Exec Order 26.4b1. On NJ Exec Order 26.4b, resident continued to c/o [complain of] NJ Exec Order 26.4b1 with PRN [as needed] NJ Exec O medication given. On NJ Exec Order 26.4b, resident's [spouse] alerted staff that resident had NJ Exec O at home and asked the nurse to look at NJ Exec Order 26.4b1. Noted NJ Exec Order 26.4b1 to NJ Exe	F 610	What corrective action will be accomplished for those residents affected by the deficient practice: " US FOIA (b)(6) were re-educated on policy for Accidents and Incident-Investigation and Reporting. US FOIA (b)(6) were educated on obtaining statements from all involved parties within 5 working days. Also, on the Abuse/Neglect Reporting by the Regional Administrator on 2/19/2024. Measures or systemic changes to ensure that the deficiencies will not recur: " The Administrator/designee will conduct compliance audits to ensure that all events of injury of unknown origin are reported and investigated as required by State Law. " The Administrator/designee will conduct audits one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 610		F 610		

Continued From page 6

NJ Exec Order 26.4b1 Further assessment done and noted NJ Exec Order 26.4b1. Resident NJ Exec Order 26.4b1 at that time. US FOI ordered NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 results showed NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1. Resident was sent out to ER [Emergency Room] and admitted with NJ Exec Order 26.4b1." Resident is NJ Exec O to NJ Exec with a BIMS [brief interview of mental status] of /15 (NJ Exec Order 26.4b1, past medical history of NJ Exec Order 26.4b1

The document titled "Investigational Summary and Conclusion", revealed: Date of Incident: NJ Exec Order 26.4b1, Incident Type: NJ Exec Order 26.4b1 Description of Event: Resident was admitted on NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 Upon admission resident c/o [complained of] NJ Exec O to NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1. On NJ Exec Order 26.4b1, resident continued to complain of NJ Exec O to NJ Exec Order 26.4b1 with PRN [as needed] NJ Exec O meds [medication] given. On NJ Exec Order 26.4b1 resident's [spouse] alerted staff that resident had a NJ Exec Order 26.4b1 and asked nurse to look at patients NJ Exec Order 26.4b1. Noted NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. Further assessment done and NJ Exec Order 26.4b1. Resident NJ Exec Order 26.4b1 at that time. US FOIA (b) (6) ordered NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 results showed NJ Exec Order 26.4b1. Resident was sent out to ER and admitted with NJ Exec Order 26.4b1.

The "Conclusion" section of the document revealed: Resident was admitted s NJ Exec Order 26.4b1. Upon admission NJ Exec Order 26.4b1. Hospital record reports that the resident had NJ Exec Order 26.4b1 and complained of NJ Exec Order 26.4b1. An NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 were obtained while

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F 610	Continued From page 7	F 610		

in the hospital and NJ Exec Order 26.4b1. A NJ Exec Order 26 was also done in the hospital of the NJ Exec Order 26.4b1 [redacted]. Resident also had a history of NJ Exe [redacted] On NJ Exec Order 26.4b [redacted], resident's [spouse] asked the staff to assess resident NJ Exec Order [redacted] as resident NJ Exec Order 26.4b1. Upon assessment NJ Exec Order 26.4b1 as documented on admission, with NJ Exec Order 26.4b1. An NJ Exec Orc [redacted] was done that resulted in a NJ Exe [redacted] p. Resident did not have a NJ Ex [redacted] in NJ Exec Order 26.4b1 and was confirmed by [spouse] and resident that the NJ Ex [redacted] occurred prior to the hospital. Based on the facts gathered and after conducting a comprehensive investigation, facility has concluded that the NJ Exec Order 26 [redacted] occurred as a NJ Exec Order 26.4b1. Resident continued to have NJ Exec Order 26.4b1 during the hospital stay however an NJ Exec Order 26.4b1 was not done. Investigational summary completed by: [JS FOIA (b) (6) name]. There were no statements obtained from any staff that cared for the resident, the spouse, and no documented evidence regarding a NJ Ex [redacted] that caused a NJ Exec Order 26 [redacted] prior to admission included, and as documented in the RE.

Review of the one page care plan attached to the Reportable Event revealed a Care Plan Focus for NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b [redacted], L NJ Exec Orde [redacted]

On 02/02/24 at 11:00 AM, the surveyor reviewed the closed electronic medical record and paper record for Resident #257 which revealed the following:

The Admission Record (an admission summary) revealed the resident had diagnoses which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 610	Continued From page 8	F 610		

included, but were not limited to; NJ Exec Order 26.4b1 [redacted]

Review of the Nursing Comprehensive Assessment, dated NJ Exec Order 26.4b at 22:04 [10:04 PM] revealed the resident was admitted from the hospital and required extensive assistance with NJ Exec Order 26.4b1 and NJ Exec Order 26. C NJ Exec Order 26.4b1 [redacted] NJ Exec O Management: 1. Received scheduled NJ Exec O medication regimen, "NJ Exec O 2. Received PRN NJ Exec O medications or was offered and declined, "NJ Exec Or 3. Received non-medication intervention for NJ Exec O, "NJ Exec was checked off. 39. Staff Assessment, Should the Staff Assessment for NJ Exec O Be Conducted, "NJ Exec was checked off.

Review of the NJ Exec Order 26.4b1 Physician Order Summary revealed the following orders:

- an order dated NJ Exec Order 26.4b at 16:56 [4:56 PM] with an end date of NJ Exec Order 26.4b for an NJ Exec Order 26.4b1 one time only for to NJ Exec Order 26.4b1 for NJ Exec Or days.

- an order dated NJ Exec Order 26.4b, Complete a NJ Exec O assessment every shift NJ Exec Order 26.4b1 [redacted] every shift.

-NJ Exec Order 26.4b1 [redacted], Give 2 tablet by mouth every 6 hours as needed for NJ Exec O NJ Exec Order 26.4b1 Order Date-NJ Exec Order 26.4b1 1916 [7:16 PM].

- NJ Exec Order 26.4b1 Give 2 tablet by

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F 610		F 610		

Continued From page 9

mouth every 6 hours as needed for NJ Exec Order 26.4b1 .do not NJ Exec Order 26.4b1 per day from all sources. -Order Date NJ Exec Order 26.4b1 at 12:15.

A review of the Medication Administration Record (MAR) and Progress Notes for NJ Exec Order 26.4b1 revealed the following:

- A Nursing Documentation Progress Note, dated NJ Exec Order 26.4b at 21:21 [9:21 PM] and signed by a US FOIA (b) (6) revealed NJ Exec Ord completed: NJ Exec Order 26.4b1 were noted."

- There was no NJ Exec Order 26.4b1 documented as administered on NJ Exec Order 26.4b

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 12:19 AM, signed by an US FOIA (b) revealed, NJ Exec Order 26.4b1 with ADL's and NJ Exec Order 26.4b [Spouse] in for visit this AM. NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 at this time, NJ Exec Order 26.4b1 noted". This contradicted the Nursing Admission Assessment dated one day prior, on NJ Exec Order 26.4b, which indicated the resident required extensive assistance with activities of daily living (ADLs).

- NJ Exec Order 26.4b1 was administered on NJ Exec Order 26.4b at 9:33 AM for a NJ Exec Order 26.4b1 There was no corresponding progress note regarding the NJ Exec Ord and there was no additional NJ Exec Order 26.4b1 documented as administered on NJ Exec Order 26.4b

- A Nursing Documentation Progress Note, dated NJ Exec Order 26.4b at 17:28 [5:28 PM], signed by an US FOIA revealed "NJ Exec Order 26.4b1

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F 610	Continued From page 10	F 610		

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 21:58 [9:58 PM], signed by a US FOIA (b) (6) revealed "Family visit most of this shift. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1. Completed care provided for NJ Exec Order 26.4b1 by one staff. Extensive assistance provided with two staff for NJ Exec Order 26.4b1, Extensive assistance provided by one staff for all s NJ Exec Order 26.4b1 , NJ Exec Order 26.4b1".

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 6:56 AM, signed by an US FOIA revealed NJ Exec Order 26.4b .

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 13:39 [1:39 PM], signed by an US FOIA revealed " NJ Exec C and NJ Exec Order 26.4b NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 ... NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 ..."

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 16:50 [4:50 PM], singed by an US FOIA revealed " NJ Exec Order 26.4b1 . Observed [with] NJ Exec Order 26.4b NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b are NJ Exec Order 26.4b1. Spouse is in room visiting at this time and stated that NJ Exec Order 26.4b1 at home prior to going to hospital. [New Order] for NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 and NJ Exec Order 26. call bell in reach and spouse at bedside assisting with dinner meal at this time."

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 610	Continued From page 11	F 610		

-A Health Status Progress Note, dated [redacted], completed by a [redacted] at 19:02 [7:02 PM]" ... [redacted]. [Spouse] at bedside. [Spouse] alerted staff about [Resident's] [redacted] and asked to look at pa[redacted]. [redacted] on [redacted] and [redacted] Resident [redacted]. Supervisor made aware." This was documented 2-hours after the [redacted] first documented that the spouse had alerted the [redacted] who observed the [redacted] of the [redacted]

Review of the Hospital Records revealed the following:

- A physician note dated [redacted], revealed a [redacted] and [redacted].

- An Occupational Treatment Note dated [redacted] at 10:40 AM revealed: [redacted] and [redacted] and ADLs. Continue to recommend [redacted] at discharge".

- A physician note dated [redacted] at 11:14 AM which revealed the patient is "[redacted] and [redacted]".

-[redacted] progress note dated [redacted] at 13:21 revealed: [redacted] and [redacted] for discharge to [redacted].

On 02/02/24 at 11:34 AM, the surveyor interviewed the [redacted] regarding the RE with 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 _____	C 02/09/2024

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F 610	Continued From page 12	F 610		

supporting documents that were provided to the surveyor and asked the US FOIA (b) if there was an additional investigation. The US FOIA (b) looked at the RE and stated "this is the investigation". The surveyor asked the US FOIA (b) what the components of an investigation included, and the US FOIA (b) stated an " incident report" and that she had one but did not bring it with her. The surveyor requested for the US FOIA (b) to provide the incident report.

On 02/02/24 at 11:39 AM, in the presence of the survey team, the US FOIA (b) stated and confirmed "I don't have an incident report for him/her", "he/she didn't have any incident", and the spouse told us the NJ Exec Order 26.4b1. The US FOIA (b) confirmed that there were no statements obtained. The surveyor asked what is typically completed regarding an investigation and the US FOIA (b) stated an incident report.

On 02/02/24 at 11:43 AM, the US FOIA (b) (6) joined the interview and the surveyor asked if reportable events were investigated and the US FOIA (b) (6) stated "yes". The US FOIA (b) and US FOIA (b) (6) confirmed that there was no investigation, or an incident report completed regarding the NJ Exec Order 26.4b1 for Resident #257. The US FOIA (b) (6) stated REs should be investigated.

The Accidents and Incidents-Investigating and Reporting Policy, adopted 10/2018 revealed: All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the Administrator. Policy Interpretation and Implementation: 1. The following data, as applicable, shall be included on the Report of Incident/Accident form: a. The date and time 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 _____	C 02/09/2024

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F 610	Continued From page 13	F 610		

accident or incident took place, b. The nature of the injury/illness (e.g. bruise, fall, nausea, etc.), c. The circumstance surrounding the accident or incident; d. Where the accident or incident took place; e. The name(s) of witnesses and their accounts of the accident or incident; f. The injured person's account of the accident or incident; g. The time the injured person's Attending Physician was notified as well as the time the physician responded and his or her instructions; h. The date/time the injured person's family was notified and by whom; i. The condition of the injured person, including his/her vital signs; j. The disposition of the injured (i.e. transferred to hospital, put to bed, sent home, returned to work, etc.); k. Any corrective action taken; l. Follow-up information; m. Other pertinent data as necessary or required; and n. The signature and title of the person completing the report. 4. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident. R.N. must complete physical assessment of resident of associated incident.

On 02/02/24 at 1:14 PM, the surveyor informed the US FOIA (b) (6) and US FOIA (b) (6) of the above concerns.

On 02/05/24 at 10:15AM, the US FOIA (b) provided the survey team with copies of hospital records including a copy of a NJ Exec Order 26.4b1, dated NJ Exec Order 26.4b with findings of NJ Exec Order 26.4b1 ". The facility did not provide any documentation including an investigation with any statements and confirmed that an incident report

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 02/09/2024

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F 610	Continued From page 14 to determine the causal factor of the NJ Exec Order 26.4b1 [redacted] was not completed.	F 610		
F 657 SS=D	NJAC 8:39-27.1(a) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it	F 657	Residents affected by deficient practice: " The facility failed to revise a	2/21/24

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 15 was determined that the facility failed to revise a resident-centered on-going Care Plan (CP) for a resident who received NJ Exec Order 26.4b1. This deficient practice was identified for 1 of 25 residents (Resident #47) reviewed for CP and was evidenced by the following: On 01/29/24 at 11:05 AM, the surveyor observed Resident #47 lying in bed. The resident was observed to be wearing a NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 attached to an NJ Exec Order 26 that was situated on the floor next to the bed. On 01/29/24 at 2:21 PM, the surveyor observed Resident #47 in his/her room lying in bed with a NJ Exec Orde the NJ Exec Order 26.4b1 attached to an NJ Exec Order 2 which was situated on the floor next to the bed. Resident #47 stated he/she was not NJ Exec Order 26.4b1 that he/she was receiving. A review of the Admission Record revealed that Resident #47 had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 A review of the quarterly Minimum Data Set (MDS) an assessment tool to facilitate resident care, dated NJ Exec Order 26.4b, included but was not limited to; a Brief Interview for Mental Status (BIMS) of NJ E/15 which indicated the resident was NJ Exec Order 26.4b1. The MDS further indicated the resident received NJ Exec Order 26.4b1 while a resident at the facility. A review of the Order Summary Report included an order dated NJ Exec Order 26.4b, fo NJ Exec Order 26.4b1 PRN (as needed) for NJ Exec Order 26.4b1 which was	F 657	resident-centered on-going Care Plan (CP) for resident #47 who received NJ Exec Order 26.4b1. Identify those individuals who could be affected by the deficient practice: " All residents who receive oxygen therapy have the potential to be affected. " The care plan for the affected resident #47 was updated immediately. " The Director of Nursing audited all care plans for patients who receive oxygen therapy with 24 hours from notification. What corrective action will be accomplished for those residents affected by the deficient practice: " US FOIA (b)(6), Unit Managers, and Nursing Supervisors were re-educated on the Care Plans, Comprehensive Person-Centered Policy on 2/19/2024 by the Regional Clinical Nurse. " All care plans for residents who receive oxygen therapy were audited. Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/Designee to conduct compliance audits for completeness of orders for residents on Oxygen. " Three random resident charts will be audited one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over 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 _____	C 02/09/2024

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

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F 657	Continued From page 16 discontinued. An order dated NJ Exec Order 26.4, to apply NJ Exec Order 26.4b1 to keep NJ Exec Order 26.4b1 every shift for NJ Exec Ord and as needed. A review of the resident-centered on-going CP failed to document a focus area, any goals, any interventions, or time frames regarding Resident #47's NJ Exec Order 26.4b1. On 02/02/24 at 9:28 AM, the US FOIA (b) (6) stated in that the information in a resident's CP included anything that pertained to resident such as if the resident was on NJ Exec Order 26.4b1 The US FOIA (b) stated that the nursing department would update their specific areas of a resident care plan. She stated that if there was a new order or diagnosis, the care plan should be updated within three days. The US FOIA (b) further stated that it was important to keep the CP updated and current because it is the "patient centered" care. On 02/02/24 at 9:51 AM, the US FOIA (b) (6) stated NJ Exec Order 2 should be included on a resident's care plan. She stated she was responsible to update the resident care plans on her unit. The US FOIA (b) (6) and the surveyor reviewed Resident #47's Care Plan. The US FOIA (b) (6) acknowledged NJ Exec Order 2 should be on the care plan, but it was not documented. The US FOIA (b) (6) further stated that it was important to have anything related to care on the care plan, so all staff would know how to care for a resident. A review of the facility provided, "Staff Nurse" job description, undated, included but was not limited to; develops a nursing care plan, individualizing the care, revises as necessary. Routinely	F 657	duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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

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F 657	Continued From page 17	F 657		

assesses the needs of the resident and adjust the care plans as needed. Reviews care plan daily to ensure that appropriate care is being rendered.

A review of the facility provided, "Nurse Manager" job description, undated, included but was not limited to; oversees or initiates care plans based on resident needs identified in the Resident Assessment Protocol and update care plans.

A review of the facility provided, "Director of Nursing" job description, undated, included but was not limited to; assist an d participate in the developing for each resident the preliminary and comprehensive assessment and plan of care that identifies medical problems and/or needs of the resident and the goals to be accomplished for each problem and/or need identified.... participate in assessing reviewing and revising care plans as required.

A review of the facility provided, "Care Plans, Comprehensive Person-Centered" policy updated 01/2023, included but was not limited to; Statement: .... Includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Interpretation and Implementation: 2. Interventions are derived from a thorough analysis of information gathered as part of the comprehensive assessment. 8. The comprehensive, person-centered care plan will: a. includes measurable objectives and timeframes; b. describes services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. g. incorporates identified problem areas; h. incorporates risk factors associated with identified problems; k. reflects treatment goals, timetables, and

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 18 objectives in measurable outcomes; identify the professional services responsible for each element of care. 13. Assessments of residents are ongoing and care plans are revised as information about the residents and the conditions change. NJAC 8:39-11.2	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #169841 Based on observation, interview, record review, and review of facility documentation, it was determined that the facility failed to maintain professional standards of nursing practice by failing to: a.) follow a physician order for [redacted] for 1 of 4 residents (Resident #95) reviewed for [redacted] and b.) administer physician prescribed medications and document physician notification for 1 of 4 closed records (Resident # 256) reviewed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential	F 658	Residents affected by deficient practice: " The facility failed to: a.) follow a physician order for [redacted] for 1 of 4 residents (Resident #95) reviewed for [redacted] and b.) administer physician prescribed medications and document physician notification for 1 of 4 closed records (Resident # 256) reviewed. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. " The affected resident # 95 was monitored for [redacted] The affected resident # 256 no longer resides in the facility. What corrective action will be accomplished for those residents affected by the deficient practice:	2/21/24

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 19 physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." a.) On 01/29/24 at 10:34 AM, during an interview with Surveyor #1 , Resident #95 was observed watching television in his/her room. The resident stated he/she had pancakes with bacon, milk, and coffee for breakfast. The surveyor observed an empty meal tray inside the room and on top of the nightstand. During an observation on 01/31/24 at 12:25 PM, the surveyor observed Resident #95 in the main dining area of [redacted] and was sitting with peers having lunch. The lunch meal tray was observed to have beef goulash over noodles, mixed vegetables, and cake. The resident had NJ Exec Order 26.4b1 of the meal at that time. A review of the medical record for Resident # 95	F 658	" All facility nursing staff were re-educated by the Director of Nursing on policies for following Physician Orders, Administering Medications, Documentation of Medication Administration, and Charting and Documentation. " All Facility nursing staff and the US FOIA (b)(6) were re-educated on Weight Assessment and Intervention Policy. " Director of Nursing/Designee audited residents who have weekly weights orders, and Medical Administration Records. Director of Nursing/Designee will conduct audit on resident #95 to ensure [redacted] are being conducted as ordered. Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/Designee to conduct compliance audits for completeness of physician orders for medications and weights. " Director of Nursing/Designee will audit Three random resident charts one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting	

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 02/09/2024

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 658	Continued From page 20	F 658		

revealed that Resident #95 had a physician order dated NJ Exec Order 26 as follows: NJ Exec Order 26.4b1, every day shift every Monday for monitoring document in NJ Exec Order 26.4b1. A review of the documented NJ Exec Order 26 in the Electronic Medical Record (EMR) revealed the following weights:

-NJ Exec Order 26.4b1
-NJ Exec Order 26.4b1
-NJ Exec Order 26.4b1
-NJ Exec Order 26.4b1
NJ Exec Order 26.4b1
-NJ Exec Order 26.4b1
-NJ Exec Order 26.4b1

The facility failed to follow the physician order written on NJ Exec Order 26 to obtain NJ Exec Order 26.4b1 for Resident #95. The facility documented NJ out of NJ NJ Exec Order for the month of NJ Exec Order 26.4b1, NJ out of NJ NJ Exec Order for the month of NJ Exec Order 26.4b1 and NJ out of NJ NJ Exec Order in the month of NJ Exec Order 26.4b1.

On 02/02/24 at 9:50 AM, surveyor interviewed the US FOIA (b) (6) The US FOIA stated that it was the responsibility of the Certified Nursing Assistant (CNA) and nurses to obtain the NJ Exec Order 26 of the residents and log them into the NJ Exec Order binder. The US FOIA stated after the weekly NJ Exec Order 26 were documented in the NJ Exec Order binder by the nurses it was the US FOIA (responsibility to transcribe them into the EMR. The US FOIA also stated that the weekly NJ Exec Order 26 needed to be logged in the EMR on Fridays every week, by the end of the day. The US FOIA stated it was important to have the US FOIA (b) (6) readily accessible in the EMR because they were used to monitor progress and make clinical judgements. The US FOIA confirmed that the weekly NJ Exec Order 26 should have been documented in the EMR for resident #95.

During an interview with the surveyor on 02/02/24

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 02/09/2024

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

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F 658		F 658		

Continued From page 21

at 10:13 AM, the US FOIA (b) (6) [redacted] or NJ Exec Orde[redacted] stated that resident had an order for NJ Exec Order 26.4b1 since NJ Exec Order 26.4b. The US FOIA (b) (6) confirmed that the weekly NJ Exec Order 26 were not documented in the EMR and they should have been. The US FOIA (b) (6) stated it is important to monitor for weekly NJ Exec Order 26 to ensure the resident gets the NJ Exec Order 26.4b1.

A review of the facility provided, "Weight Assessment and Intervention" policy interpretation and implementation updated 11/2023, included but was not limited to; #2. Weights will be recorded in the resident's electronic medical record, #8. It is the responsibility of the nursing to obtain and enter weights upon admission/readmission into the facility and also to obtain and enter daily weights as ordered by the MD (Medical Doctor).

A review of the facility provided job description of the Dietitian, undated, included but was not limited to; Duties and Responsibilities:
-Provides and maintains accurate documentation
-Plans, implements, and reports on performance improvement activities and directs quality assurance audits
-Ensures compliance with state and other regulatory agencies.

b.) A review of the closed medical record for Resident #256 revealed diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the "first assessment" Minimum Data Set (MDS) an assessment tool used to

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 02/09/2024

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 658	Continued From page 22	F 658		

facilitate resident care, dated NJ Exec Order 26.4b included but was not limited to; a Brief Interview for Mental Status of NJ Exec /15 which indicated the resident was NJ Exec Order 26.4b1 A review of the resident-centered on-going care plan included but was not limited to; focus area has NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1, NJ Exec with interventions that included to monitor medications for side effects. A focus area of NJ Exec Order 2 related to NJ Exec Order 26.4b1 A review of the Order Summary Report included but was not limited to; a physician's telephone order dated NJ Exec Order 26.4b, for NJ Exec Order 26.4b1 give one tablet by mouth one time a day. A physician's telephone order dated NJ Exec Order 26.4 NJ Exec Order 26.4b1 give two tablets by mouth at bedtime for NJ Exec Order 26.4b1 hold for NJ Exec Order 26.4b1

A review of the Medication Administration Record (MAR) dated NJ Exec Orde through NJ Exec Order 2, included but was not limited to; the physician ordered NJ Exec Order 26.4b1 plotted for 1800 (6:00 PM) with an "x" for the date NJ Exec Order 2. The physician ordered NJ Exec Orde plotted for 2100 (9:00 PM) with an "x" for the date NJ Exec Order 2. The MAR had documentation that five other physician ordered medications were administered on the evening shift to Resident #256. The MAR contained "chart codes" which have a numeric value to explain why a medication was not administered. The MAR did not include the numeric value from the chart code for the NJ Exec Order 26.4b1 or the NJ Exec Orde only an "x". The MAR did not reveal any circle or staff initial per facility policy to indicate the medication was either withheld, refused, or given at a time other than the scheduled time.

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 658	Continued From page 23 A review of the Progress Notes (PN) included but were not limited to; documentation starting on [NJ Exec Order 2]. The PNs failed to include any documentation that the physician was notified that Resident #256 had not received his/her [NJ Exec Order 26.4b1] or [NJ Exec Order 2]. The PNs also failed to document any monitoring or response related to Resident #256s omission of the two medications. On 01/31/24 at 8:40 AM, Surveyor #2 interviewed the US FOIA (b) (6) [redacted]. The [US FOIA (b) (6)] stated that if there was no documentation, the medication was not administered. The [US FOIA (b) (6)] further stated that any medications not administered would be noted why and the physician would also be notified. On 02/05/24 at 10:10 AM, during an interview with the surveyors, the US FOIA (b) (6) [redacted] was asked what the expectation was for the staff who administered medications. The [US FOIA (b)] stated the medication should be documented and that if it was not administered, the physician should be notified. A review of the facility provided, "Staff Nurse" job description, undated, included but was not limited to; Purpose: provide direct nursing care to residents under the medical direction of the residents; attending physicians.... Charting and Documentation duties: charts relevant, concise, and descriptive manner that reflects the care provided to the resident and the resident's response to care. Planning and Delivery of care: assures resident care delivery in accordance with facility policies and procedures. Is responsible for administering and documenting medications according to the physician's order.	F 658		

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 24 A review of the facility provided, "Administering Medications" policy, updated 1/2023, included but was not limited to; medications are administered in a safe and timely manner as prescribed. 4. Medications are administered in accordance with prescriber orders, including any required time frame. 5. Medication administration times are determined by resident need and benefit. 17. For residents otherwise unavailable to receive medication, the MAR may be "flagged". After completing the medication pass, the nurse will return to the missed resident to administer the medication. 18. If a drug is withheld or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space for that drug and dose. A review of the facility provided, "Documentation of Medication Administration" policy, updated 1/2023, included but was not limited to; Interpretation and Implementation: 3. Documentation of medication includes as a minimum: f. reason(s) why a medication was withheld, not administered, or refused. A review of the facility provided, "Charting and Documentation" policy, updated 1/2023, included but was not limited to; Policy: all services provided progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition. 2. The following information is to be documented. b. medications administered.	F 658		

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 25 The facility failed to administer two medications to Resident #256. The facility failed to document the reasoning the medications were not administered or that staff contacted the physician regarding the medications for any physician orders if needed. NJAC 8:39-27.1, 29.3(5)	F 658		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview, record review and document review it was determined that the facility failed to recognize a NJ Exec Order 26.4b1 and ensure that no delay in treatment occurred, when on NJ Exec Order 26.4b, a resident presented with NJ Exec O accompanied by an NJ Exec Order 26.4b1 and the resident was not immediately assessed by a Registered Nurse, and waited over 24 hours to NJ Exec Order 26.4b1 and was then transferred to the Emergency Room. This deficient practice occurred for 1 of 1 resident (Resident #257) reviewed for NJ Exec Order 26.4b1. Resident #257 was diagnosed with an NJ Exec Order 26.4b1 which required NJ Exec Order 26 on NJ Exec Order 26.4b for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 of the NJ Exec Order 26.	F 684	Residents affected by deficient practice: " The facility failed to recognize a NJ Exec Order 26.4b1 and ensure that NJ Ex occurred for Resident #257 Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. " The affected resident # 257 no longer resides in the facility. What corrective action will be accomplished for those residents affected by the deficient practice: " All facility Registered Nurses,	2/21/24

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 684	Continued From page 26 Refer to 610G The evidence was as follows: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding, reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 02/02/24 at 9:58 AM the surveyor, in the presence of the survey team, interviewed the US FOIA (b) (6)) regarding reportable events and the Quality Assurance and Performance Improvement process. The surveyor inquired about any recent significant events and the US FOIA (b) informed the surveyor about	F 684	Certified Nursing Assistants and Licensed Practical Nursing staff were re-educated by the Director of Nursing on the Resident Evaluation/Assessment of original policy to ensure that nursing staff evaluates and assesses the residents for any physical abnormalities and any changes in pain levels in health status within 24 hours. " Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/Designee to conduct compliance audits to ensure that any residents with change of status in physical condition and pain have been identified and proper interventions are in place to prevent delay in treatment. " Director of Nursing/Designee will audit three random resident charts one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 27	F 684		

Resident #257 who sustained a NJ Exec Order 26.4b1 The surveyor inquired further about what was completed regarding the incident, and the US FOIA (6 stated the NJ Exec Order 26.4b1 and "I just did an investigation" and then provided the surveyor with a copy of a Reportable Event (a required document to be submitted to the Department of Health).

Review of the documents attached to the Reportable Event (RE) included a titled, "Investigational Summary and Conclusion", one page of a Care Plan, and copies of fax transmissions dated NJ Exec Order 26.4b to the Department of Health and Ombudsman's office.

A review of the RE dated NJ Exec Order 26.4b and Person Reporting: US FOIA (b) (6) revealed: Date of Event: NJ Exec Order 26.4b and Time of Event: 9:42 PM; NJ Exec Order 26.4b1 ". The Type of Incident: " NJ Exec Order Narrative- 1. Describe the event, to include timeframes/risk factors related to the incident/event (relevant resident diagnosis): "Resident was admitted on NJ Exec Order 26.4 NJ Exec Order 26.4b1. On admission resident c/o [complained of] NJ Exec Order 26.4b1, with NJ Exec Order 26.4b1. On NJ Exec Order 26.4b, resident continued to c/o [complain of] NJ Exec O to NJ Exec Order with PRN [as needed] NJ Exec O medication given. On NJ Exec Order 26.4b resident's [spouse] alerted staff that resident had a NJ Exec Order 26.4b1 and asked the nurse to look at NJ Exec Order 26.4b1. Noted NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1. Further assessment done and noted NJ Exec Order 26.4b1. Resident NJ Exec Order 26.4b1 at that time. US FOIA (b)(6) ordered NJ Exec Order 26.4b1. NJ Exec Ord results showed NJ Exec Order 26.4b1. Resident was sent out to ER [Emergency Room] and admitted with NJ Exec Order 26.4b1." Resident is NJ Exec O to

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 28	F 684		

NJ Exec O with a BIMS [brief interview of mental status] of /15 (NJ Exec Order 26.4b1), past medical history of NJ Exec Order 26.4b1 3. What interventions were implemented after the incident/event? For example, supervision, resident sent to hospital, US FOIA (b)(6) suspended. Please describe investigative findings/conclusions: "Resident NJ Exec Order 26.4b1 at the time, NJ Exec Order 26.4b1 Doctor and family aware, NJ Exec Ord was done, and results showed NJ Exec Order 26.4b1 of the NJ Exec Resident was sent out to the hospital for further evaluation, Care plan to be updated upon return." There were no Registered Nurse assessments attached to the documentation.

The document titled "Investigational Summary and Conclusion", revealed: Date of Incident: NJ Exec Order 26.4b, Incident Type: NJ Exec Order 26.4b Description of Event: Resident was admitted on NJ Exec Order 26.4b, NJ Exe Upon admission resident c/o [complained of] NJ Exec O to NJ Exec Order 2 with NJ Exec Order 26.4b1. On NJ Exec Order 26.4 , resident continued to NJ Exec Order 26.4b1 with PRN [as needed] NJ Exec O meds [medication] given. On NJ Exec Order 26.4b1 resident's [spouse] alerted staff that resident NJ Exec Order 26.4b1 and asked nurse to look at NJ Exec Order 26.4b1. Noted NJ Ex Order 2 to NJ Exec Order 26.4b1. Further assessment done and NJ Exec Order 26.4b1. Resident NJ Exec Order 26.4b1 at that time. US FOIA (b)(6) ordered NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 showed NJ Exec Order 26.4b1 . Resident was sent out to ER and admitted with NJ Exec Order 26.4b1.

The Action: section revealed "Resident NJ Exec Order 2 at the time NJ Exec Order 26.4b1 was ordered, US FOIA and family aware, Resident rested in bed until

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 02/09/2024

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F 684	Continued From page 29	F 684		

[redacted] results obtained".

Follow Up Action: "Resident rested in bed until [redacted] were obtained, Resident [redacted] at the time, Resident sent out to ER (Emergency Room) for further evaluation, Review of nurses notes and any incidents, Review of hospital records and [redacted] reports."

The "Conclusion" section of the document revealed: Resident was admitted [redacted] at home. Upon admission residents [redacted]. Hospital record reports that the resident [redacted] and complained of [redacted]. An [redacted] of [redacted] and [redacted] were obtained while in the hospital and [redacted]e. A [redacted] was also done in the hospital of the [redacted] to resident's [redacted] that was [redacted]. Resident also had a [redacted]. On [redacted] resident's [spouse] asked the staff to assess resident [redacted] resident [redacted] at home. Upon assessment [redacted] as documented on admission, with [redacted] An [redacted] was done that resulted in a [redacted]. Resident did not have [redacted] in [redacted] and was confirmed by [spouse] and resident that [redacted] prior to the hospital. Based on the facts gathered and after conducting a comprehensive investigation, facility has concluded that the [redacted] occurred as a [redacted] sustained at home. Resident continued to have [redacted] during the hospital stay however [redacted] of the [redacted]. Investigational summary completed by: [redacted] name]. There were no statements obtained from any staff that cared for the resident, the spouse, and no documented

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 30	F 684		

evidence regarding a [redacted] that caused a [redacted] prior to admission was included, and as documented in the RE.

On 02/02/24 at 11:00 AM, the surveyor reviewed the closed electronic medical record [EMR] and paper record for Resident #257 which revealed the following:

Review of the Nursing Comprehensive Assessment dated [redacted] at 22:04 [10:04 PM] revealed the resident was admitted from the hospital and required extensive assistance with [redacted] and [redacted] C. [redacted], Site: [redacted] Management: 1. Received scheduled [redacted] medication regimen, "[redacted] 2. Received PRN [redacted] medications or was offered and declined, "[redacted] 3. Received non-medication intervention for [redacted] was checked off. 39. Staff Assessment, Should the Staff Assessment for [redacted] Be Conducted, "[redacted] was checked off.

Review of the [redacted] Physician Order Summary revealed the following orders:

- an order dated [redacted] at 16:56 [4:56 PM] with an end date of [redacted], [redacted], order summary, one time only for [redacted] for [redacted] days]. The [redacted], Date of Service [redacted] at 2:28 PM, revealed [redacted] There was handwritten documentation on the result which revealed" called to [primary medical doctor, [redacted] at

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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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F 684	Continued From page 31	F 684		

9:45 PM" (approximately 5 hours later). There was no [NJ Exec Order 26.4b1] ordered, as documented in the RE that was submitted to the Department of Health, and as documented as the action taken.

-there was no order for [NJ Exec Order 26.], or any other orders related to [NJ Exec Order 26.4b1] or [NJ Exec Order 26.] while [NJ Exec Order 26.4b1].

-the Care Plan was reviewed and did not contain any interventions related to caring for the resident when [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] [NJ Exec Order 26.4b] was identified on [NJ Exec Order 26.4b1]

- an order dated [NJ Exec Order 26.4b], Complete a [NJ Exec O] assessment every shift [NJ Exec Order 26.4b1] every shift.

-[NJ Exec Order 26.4b1] Give 2 tablet by mouth every 6 hours as needed for [NJ Exec O] [NJ Exec Order 26.4b1], Order Date-[NJ Exec Order 26.4b1] 1916 [7:16 PM].

-[NJ Exec Order 26.4b1], Give 2 tablet by mouth every 6 hours as needed for [NJ Exec Order 26.4b1] do not exceed [NJ Exec Order 26.] per day from all sources. -Order Date-[NJ Exec Order 26.4b] at 12:15.

A review of the Medication Administration Record (MAR) and Progress Notes for [NJ Exec Order 26.4b1] revealed the following:

- A Nursing Documentation Progress Note, dated [NJ Exec Order 26.4b] at 21:21 [9:21 PM] and signed by a US FOIA (b)(6) revealed [NJ Exec O]

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 02/09/2024

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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F 684	Continued From page 32	F 684		

- There was no NJ Exec Order 26.4b1 documented as administered on NJ Exec Order 26.4b

-A Health Status Progress Note, dated NJNJ Exec Order 26 at 12:19 AM, signed by an US FOIA (b) revealed, "NJ Exec Order 26.4b1 with ADL's and NJ Exec Order 26.4b [Spouse] in for visit this AM, NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 at this time, NJ Exec Order 26.4b1". This contradicted the Nursing Admission Assessment dated one day prior, on NJ Exec Order 26.4b, which indicated the resident required extensive assistance with activities of daily living (ADLs).

- NJ Exec Order 26.4b1 was administered on NJ Exec Order 26.4b at 9:33 AM for a NJ Exec Order 26.4b1. There was no corresponding progress note regarding the NJ Exec Ord and there was no additional NJ Exec Order 26.4b1 documented as administered on NJ Exec Order 26.4b

- The NJ Exec O Assessment Every Shift Section in the MAR for NJNJ Exec Order 2 was documented at " NJ E NJ Exec O level for all three shifts. This contradicted the MAR when the NJ Exec Order 26.4b1 was administered on NJ Exec Order 26.4b at 9:33 AM.

- A Nursing Documentation Progress Note, dated NJ Exec Order 26.4b at 17:28 [5:28 PM], signed by an US FOIA revealed "NJ Exec Order 26.4b1 ."

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 21:58 [9:58 PM], signed by a US FOIA (b)(6) revealed "Family visit most of this shift. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 to questions." NJ Exec Order 26.4b1. Completed care provided for NJ Exec Order 26.4b1 by one staff. Extensive assistance provided with two staff for NJ Exec Order 26.4b1, Extensive assistance

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 33	F 684		

provided by one staff for all NJ Exec Order 26.4b1 . "NJ Exec Order 26.4b1".

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 6:56 AM, signed by an US FOIA revealed "NJ Exec Order 26 . NJ Exec Order 2 ".

-The MAR dated NJ Exec Order 26.4b did not reveal any documented NJ Exec Order 26.4b1 administration for the entire day.

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 13:39 [1:39 PM], signed by an US FOIA revealed 'NJ Exec C and NJ Exec Order 26.4 NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 ... NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 ..."

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 16:50 [4:50 PM-3 hours later], also signed by an US FOIA revealed NJ Exec Order 26.4b1 [with] NJ Exec Order 26.4b1 , a NJ Exec Order 26.4b1 , and NJ Exec Order 26.4b1 and NJ Exec Order 26.4b are NJ Exec Order 26.4b1. Spouse is in room visiting at this time and stated that NJ Exec Order 26.4b1 at home prior to going to hospital. [New Order] for NJ E NJ Exec Order 26.4b1 . NJ Exec Order 26.4b1 and NJ Exec Order 26. call bell in reach and spouse at bedside assisting with dinner meal at this time". The was no documented US FOI assessment, and the surveyor reviewed the Assessment section of the medical record which did not included a documented US FOIA (b)(6) assessment, after the resident presented with the NJ Exec O NJ Exec Orde

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 34	F 684		

and NJ Exec Order 26.4b1, and no clarification to the documentation regarding the "NJ Exec Order 26.4b1".

-A Health Status Progress Note, dated NJ Exec Order 26.4b at 17:04 PM [5:04 PM] and completed by the US FOIA revealed spoke with the NJ Exec Order 26.4b1 and the tech [technician] will be at the facility to complete NJ Exec Order 26.4b1.

-A Health Status Progress Note, dated NJ Exec Order 26.4b1 completed by a US FOI at 19:02 [7:02 PM]" ... NJ Exec Ord. [Spouse] at bedside. [Spouse] alerted staff about [Resident's] NJ Exec Order 26.4b1 and asked to look at NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Orde on NJ Exec Ord NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Resident NJ Exec Order 26.4b1. Supervisor made aware." This was documented 2-hours after the US FOIA first documented that the spouse had alerted the US FOIA (D) who observed the NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 11:00 AM, completed by an US FOIA revealed "Received resident NJ Exec O and NJ Exec Order 26.4b1 NJ Exec Order 2. [Complained of NJ Exec Order 26.4b1 and administered [as needed] NJ Exec Order 26 Vital signs NJ Exec Order NJ Exec Order 26.4b1 NJ Exec Order 26.4b1

-The MAR revealed NJ Exec Order 26.4b1 was administered for a NJ Exec Order 26.4b1 at 8:21 AM and 17:38 [5:38 PM].

-A Health Status Progress Note, dated NJ Exec Order 26.4b at 16:59 [4:59 PM], documented by the US FOIA revealed " ... Resident NJ Exec O with NJ Exec Order 26.4b1 NJ Exec O

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 35	F 684		

NJ Exec Orc and NJ Exe ... Minimal assist of 1 with ADL's and NJ Exec Order 26.4b [Spouse] in for visit. NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 at this time. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1.

- A Health Status Progress Note, dated NJ Exec Order 26.4b at 21:23 [9:23 PM], documented by the US FOIA revealed "Received final report for NJ Exec Order 26.4b1 and reads as follows: NJ Exec Order 26.4b1 . Placing call out to [Primary Medical Doctor].

-A Health Status Progress Note, dated NJ Exec Order 26.4b at 21:37 [9:37 PM], documented by the US FOIA revealed spoke with [primary medical doctor and new order] received send to [Emergency Room] for NJ Exec Order 26.4b1. Spouse notified. "911 notified".

-A US FOIA (b)(6) Progress Note, dated NJ Exec Order 26.4b1 at 11:58 AM, documented by the US FOIA revealed a History of NJ Exec Order 26.4b1. "Presented to the Emergency Room with NJ Exec Order 26.4b1 Patient was admitted on NJ Exec Order 26.4b for management of NJ Exec Order 26.4b1 of the NJ Exec O of the NJ Exe NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 occurred on NJ Exec Order 26.4b. Patient was optimized for discharge on NJ Exec Order 26.4b. Patient seen today in NJ Exec Order 26.4b1].

On 02/01/24 at 11:11 AM, the surveyor interviewed an LPN (LPN #1) who worked on the NJ Exec Order 26.4b1 unit where Resident #257 resided regarding who would document an order for a NJ Exec Order 26.4b1 and what would be completed if there

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 36	F 684		

was a change in condition. The [US FOIA] stated supervisors would enter the [NJ Exec Ord] order, and the nurses would be responsible to complete a [NJ Exec O] assessment and [NJ Exec Order 26.4b1] under the assessment task.

On 02/02/24 at 1:03 PM, the surveyor conducted a telephone interview, in the presence of the survey team, with the US FOIA (b)(6) for Resident #257. The surveyor inquired if there was a delay for over 24 hours in providing an [NJ Exec Ord] for a resident who presented with an NJ Exec Order 26.4b1 what should occur. The [US FOIA] stated he would expect to be notified by the nurse if an [NJ Exec Ord] could not be completed right away then resident should be sent to the hospital and the resident could always return. The [US FOI] stated, regarding the NJ Exec Order 26.4b1 that was observed, if the [NJ Exec Ord] cannot be completed within 24 hours, the resident would need to go somewhere where the NJ Exec Order 26.4b1 ".

On 02/02/24 at 1:14 PM, the surveyor informed the US FOIA (b)(6) and US FOIA (b)(6) of the above concerns.

On 02/05/24 at 10:10 AM, the survey team conducted an exit interview with the US FOIA (b)(6) The [US FOIA (b)] confirmed that there was no incident report completed. The [US FOIA (b)] did not provide any orders or documentation to confirm that the resident NJ Exec Order 26.4b1. The [US FOIA (b)] did not offer any additional information regarding why the order for the [NJ Exec Ord] was not for [NJ Exec Order 26.4] as documented as the action taken in the RE, or any documented [US FOIA] completed when the NJ Exec Order 26.4b1 was identified 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 _____	C 02/09/2024

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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F 684	Continued From page 37 09/23/23. The [US FOIA (b)(6)] stated to the survey team, that the [NJ Exec Order 26] did NJ Exec Order 26.4b1, after the [US FOIA (b)] had provided the survey team with copies of hospital records including a copy of a [NJ Exec Order 26.4b1], dated [NJ Exec Order 26.4b] with findings of "NJ Exec Order 26.4b1". When asked why there was a delay in providing an [NJ Exec Or], the [US FOIA (b)(6)] stated, "[NJ Exec Order 26.4b1]", "[NJ Exec O]" confirmed it was 30 hours later, but it was done and the [NJ Exec Order 26] was addressed. A review of the following policies revealed: The Resident Evaluation/Assessment Policy, revised 01/2023, The purpose of this procedure is to evaluate or assess the resident for any abnormalities in health status, which provides a bis for the care plan. Documentation: The following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual(s) who performed the procedure. 3. All assessment data obtained during the procedure. 4. How the resident tolerated the procedure. 5. If the resident refused the procedure, the reason(s) why and the intervention taken. 6. The signature and title of the person recording the data. Reporting: 1. Notify the supervisor if the resident refuses the examination. 2. Notify the physician of any abnormalities such as, but not limited to: a. abnormal vital signs; e. wounds or rashes on the resident's skin, f. worsening pain as reported by the resident. 3. Report other information in accordance with facility policy and professional standards of practice. NJAC 8:39-27.1(a)	F 684		

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 38	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to follow physician orders for the NJ Exec Order 26.4b1 at NJ Exec Order 26.4b1. This deficient practice was identified for 2 of 2 residents (Resident #34 and #47) reviewed for NJ Exec Order 2 and was evidenced by the following: a.) On 01/29/24 at 9:39 AM, the surveyor toured the Unit [redacted] and observed Resident #34 lying in bed NJ Exec Order and NJ Exec O The surveyor observed that Resident #34 had a NJ Exec Order 26.4b1, and the NJ Exec Orde was attached to an NJ Exec Order 26 which was situated on the floor next to the bed. The NJ Exec Order 26.4b1. Resident #34 stated that staff had told him/her their NJ Exec Order 26.4b1 was NJ Exec and he/she needed to use NJ Exec Order 26 and he/she had never NJ Exec Order 26.4b1 before. Resident #34 stated the NJNJ Exec Order 26.4b1 A review of the Admission Record revealed that Resident #34 had diagnoses which included but were not limited to; NJ Exec Order 26.4b1	F 695	Residents affected by deficient practice: " The facility failed to follow physician orders for the NJ Exec Order 26.4b1 This deficient practice was identified for 2 of 2 residents (Resident #34and #47) Identify those individuals who could be affected by the deficient practice: " All residents who have physician orders for oxygen therapy have the potential to be affected. " The NJ Exec Order 26.4b1 for the affected residents # 34 and #47 were checked and confirmed to be maintained at the proper settings per the physician orders. What corrective action will be accomplished for those residents affected by the deficient practice: " All facility nursing staff were re-educated by the Director of Nursing on the Oxygen Administration and Administering Medication policies to ensure that nursing staff follows the	2/21/24

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 02/09/2024

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

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F 695	Continued From page 39 NJ Exec Order 26.4b1 A review of the Annual Minimum Data Set (MDS) an assessment tool to facilitate resident care, dated NJ Exec Order 26.4b1, included but was not limited to; a Brief Interview for Mental Status (BIMS) of NJ Exec Order 26.4b1/15 which indicated Resident #34 was NJ Exec Order 26.4b1. Section NJ Exec Order 26.4b1 revealed the resident was NJ Exec Order 26.4b1 on staff for NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1; and the resident was NJ Exec Order 26.4b1 or to NJ Exec Order 26.4b1. Section NJ Exec Order 26.4b1 indicated the resident received NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 while a resident at the facility. A review of the Order Summary Report included but was not limited to; an order dated NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 A review of the resident-centered on-going care plan included but was not limited to; a focus area of ADL (Activities of Daily Living) NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. Interventions included resident requires staff assistance to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 and to NJ Exec Order 26.4b1. A focus area of prescribed NJ Exec Order 26.4b1, Related to NJ Exec Order 26.4b1. Interventions included monitor for signs and symptoms of NJ Exec Order 26.4b1. On 01/29/24 at 2:17 PM, the surveyor observed Resident #34's NJ Exec Order 26.4b1 at 3.5 lpm. This was not at the physician prescribed order of NJ Exec Order 26.4b1. On 01/29/24 at 2:27 PM, the direct care US FOIA (b)(6) stated that Resident #34 had a physician order for NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that she checked the NJ Exec Order 26.4b1 in the morning. The US FOIA (b)(6) and surveyor went into Resident #34's room. The US FOIA (b)(6) then	F 695	physician orders for the oxygen settings. " All residents on oxygen were audited. Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/Designee to conduct compliance audits to ensure that any residents with physician orders for the oxygen have the proper settings. " Director of Nursing/Designee will conduct three random resident charts one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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 02/09/2024

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 695	Continued From page 40	F 695		

acknowledged the NJ Exec Order 2 was NJ Exec Order 26.4b1 and stated it "NJ Exec Order 26.4b1". She further stated that NJ Exec Order 26.4b1 can cause NJ Exec Order 26 and NJ Exec Order 26.4b1 to the resident.

b.) On 01/29/24 at 11:05 AM, a surveyor observed Resident #47 lying in bed. The surveyor observed the resident was NJ Exec Order 26.4b1 and the NJ Exec Orde was attached to an NJ Exec Order 26.4b1 which was situated on the floor next to the bed. The surveyor observed that the NJ Exec Order 2 was set to NJ Exec Orde

On 01/29/24 at 2:21 PM, the surveyor observed Resident #47 in bed with the NJ Exec Orde the NJ Exec Orde was attached to the NJ Exec Order 26.4b1 which was situated on the floor next to the bed. The surveyor asked the resident if he/she knew what NJ Exec Order 26.4b1 he/she should be using. Resident #47 stated he/she believed it was NJ Exec Order 26.4b1 The surveyor observed the NJ Exec Order 2 was set at NJNJ Exec O.

A review of the Admission Record revealed that Resident #47 had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 . A review of the quarterly MDS dated NJNJ Exec Order 26, included but was not limited to; a BIMS of NJ E /15 which indicated the resident was NJ Exec Order 26.4b1. Section NJ E revealed that Resident #47 received NJ Exec Order 26.4b1 while a resident at the facility. A review of the Order Summary Report revealed an active order dated NJ Exec Order 26.4b, apply NJ Exec Order 2 per NJ Exec Order 26.4b1 . A review of the Treatment Administration Record (TAR) dated NJ Exec Order 2 through NJ Exec Order 26, documented that on NJNJ Exec Order 26, the nurse on the day shift signed off

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 02/09/2024

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

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F 695	Continued From page 41	F 695		

that the NJ Exec Order 2 at NJ Exec Orc was administered. A review of the resident-centered on-going comprehensive care plan failed to document the resident's use of NJ Exec Order 26.4b1, any focus area, goal, interventions, or time frames.

On 01/29/24 at 2:35 PM, the direct care US FOIA (b)(6)) stated that the night shift should check the NJ Ex Order 26.4b1 for Resident #47 and stated, "to be honest, I did not look at it [NJ Exec Order 26.4b1] today". The US FOIA and the surveyor went to the resident's room where the US FOIA observed and acknowledged that Resident #47's NJ Exec Order 2 was NJ Exec Order 26.4b1. The US FOIA stated that NJ Exec Order 26.4b1 of a level could NJ Exec Orde " The US FOIA was unable to NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 at that time, and the US FOIA removed the NJ Exec Order 26.4b1 and obtained and set up a NJ Exec Order 26.4b1 .

On 01/29/24 at 2:39 PM, the US FOIA (b)(6) stated that the nurses should be checking the resident's NJ Exec Order 26.4b1 every shift. She stated that if NJ Exec Order 2 was NJ Exec Order 26.4b1, a resident could become NJ Exec Order 26.4b1 on NJ Exec Order 26 She stated that Resident #34 had NJ Exec Order and NJ Exec Order 2 set NJ Exec Order 26 can make the NJ Exec Order NJ Exec Order

A review of the facility provided, "Staff Nurse" job description undated, included but was not limited to; execution of physician's orders.... periodic (at least daily) rounds to observe and evaluate the resident's physical and emotional status and to ensure continuing quality resident care. Is responsible for administering and documenting medications according to the physician order.

A review of the facility provided, "Oxygen

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 02/09/2024

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F 695	Continued From page 42 Administration" policy, updated 1/2023, included but was not limited to; Purpose: to provide guidelines for safe oxygen administration. Preparation: review the physician's orders... Steps: 7. Adjust the oxygen delivery device for ..... the proper flow of oxygen. A review of the facility provided, "Administering Medication" policy, updated 1/2023, included but was not limited to; Purpose: medications are administered in a safe and timely manner and as prescribed. Policy: 4. administered in accordance with the prescriber's orders.... NJAC 8:39-27.1 (a)	F 695		
F 761 SS=E	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	F 761		2/21/24

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 43 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, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure resident specific prescription medications were stored securely. This deficient practice was identified for 1 of 2 units (Unit 2) observed and was evidenced by the following: On 01/31/24 at 6:13 AM, the surveyor observed two nurses on Unit [redacted] working at their medication carts. One nurse was at the [redacted] of the hall, and the second nurse was at the [redacted] of the hall. Both nurses were observed actively working at their nursing carts. The surveyor walked down toward the low end of the hall, toward the middle of the unit and observed a third nursing medication cart. The third nursing medication cart was placed up against a wall across from the nursing desk. The surveyor observed six bingo cards (a pop out pill dispensing system) with resident names printed on them, with prescription medication inside the bingo cards, a container with a resident name printed on it that contained prescription eye drops, and a prescription inhaler system with a resident name on the label. The surveyor remained at the nursing desk and observed two housekeeping staff walking past the accessible, unsecured prescription medications. On 01/13/24 at 6:35 AM, one of the nurses who was identified as an agency [redacted] approached the third medication	F 761	Residents affected by deficient practice: " The facility failed to ensure resident specific prescription medications were stored securely on unit 2. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. " The medications were removed and stored securely upon notification. " A thorough inspection of all facility medication carts and medication rooms was conducted by the Administrative Nursing Team on 1/31/2024 to ensure that all medications were properly stored. What corrective action will be accomplished for those residents affected by the deficient practice: " All facility nursing staff were re-educated on the Administering Medication and Storage of Medication policies to ensure that nursing staff follows the proper protocols, and all medications must be secured properly. Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/Designee to conduct compliance audits to ensure all medications are stored properly per the	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 761	Continued From page 44 cart with the unsecured prescription medications on top. At that time, the surveyor inquired why the medications were sitting on top of the medication cart. The US FOIA stated, "logically they [the prescription medications] should be put away, but I did not sign for their delivery." The US FOIA opened the bottom drawer of the third medication cart and placed all the prescription medications that had been delivered inside the drawer and then locked the medication cart. On 01/31/24 at 6:37 AM, the second nurse who was identified as the facility US FOIA (b)(6) stated she had signed for the delivery of those medications but did not secure them because the US FOIA had the keys to the third medication cart. The US FOIA stated that the medications should have been secured when they were delivered, and not left on top of the medication cart. On 01/31/24 at 8:38 AM, the US FOIA (b)(6)) and the US FOIA (b)(6) were made aware of the prescription medications being unsecured and out of direct sight of the nurses for 22 minutes, and staff observed walking passed the medication on the unit. At that time, the US FOIA (b) stated the process was that medications would be delivered, and the nurses would be responsible to reconcile the medications against the delivery sheet from the pharmacy. She further stated that the medications would be given to the nurse who was responsible for that resident's medications in the medication cart. The US FOIA (b) stated that medications left unsecured on top of a medication cart was unacceptable because anyone could have taken them.	F 761	policy. " Three random medication carts on different shifts will be audited one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 45 On 01/31/24 at 9:14 AM, the 7:00 AM to 3:00 PM, US FOIA on Unit [redacted] stated the process for prescription medication deliveries was that the nurse who accepted the delivery would reconcile the medications with the pharmacy delivery sheet. The medications would be delivered to their respective medication carts depending on the resident, and "taken care of right away". Narcotics would require the signature of two nurses. The US FOI stated that prescription medication should never be left unattended because anyone, even residents, could take them. On 01/31/24 at 9:25 AM, the US FOIA (b)(6) consultant in the presence of the survey team, stated "the nurses should have eyes on it [the delivered prescription medications] at all times." She further stated that all medications should be stored behind a lock, "it is a law" and that there could be residents who could swallow the unattended medications. The US FOIA (b)(6) consultant stated that medications were "easy enough" to pop out of the bingo cards. A review of the facility provided Packing Slip Proof of Delivery, dated 1/31/24, revealed that the agency US FOIA had signed for the pharmacy delivered medications at 5:28 AM. A review of the facility provided, "Staff Nurse" job description undated, included but was not limited to; performs all tasks in accordance with established policies and procedures. Ensures a safe environment. A review of the facility provided, "Administering Medications" policy updated 1/2023, included but was not limited to; 16. ..... the medication cart is	F 761		

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 761	Continued From page 46 kept closed and locked when out of sight of the nurse. No medications are kept on top of the cart. The cart must be clearly visible.... must be inaccessible to residents or others passing by. A review of the facility provided, "Storage of Medications" policy, updated 1/2023, included but was not limited to; heading: store all drugs and biologicals in a safe, secure, and orderly manner. Interpretation and Implementation: 1 .... Stored in locked compartments .... Only persons authorized to prepare and administer medications have access to locked medications. 3. The nursing staff is responsible for maintaining medication storage ..... in a clean, safe, and sanitary manner. 6. Compartments containing drugs and biologicals are locked when not in use. NJAC 8:39-27.1, 29.3(h)	F 761		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review it was determined that the facility failed to ensure meals were served at a palatable temperature for 6 of 6 residents who attended a resident council meeting, and on 2 of 3 units	F 804	Residents affected by deficient practice. The facility failed to ensure meals were served at a palatable temperature for 6 of 6 residents who attended a resident council meeting, and on 2 of 3 units	2/21/24

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F 804	Continued From page 47 reviewed for food temperatures. The deficient practice was evidenced by the following: On 01/30/24 at 11:04 AM, the surveyor conducted a resident council meeting with six residents. The surveyor inquired about the meals served and 6/6 residents interviewed stated the [hot food] was "always served cold" and especially the coffee. On 01/31/24 at 7:30 AM, surveyor #1 observed the meal truck enter [redacted] The first meal tray was passed at 7:31 AM, and the last meal tray was passed at 7:49 AM. At that time, the surveyor removed the last meal tray and completed a test meal observation, in the presence of the [redacted] with the following recorded temperatures: Oatmeal: 136 degrees Farenheight (F) Sausage: *112 F 2 Pancakes: *120 F 4-ounce Orange Juice: *51 F 8-ounce Low Fat Milk: *56 F Coffee: *112 F On 01/31/24 at 8:40 AM, surveyor #2 observed the meal cart arrive on [redacted] and the last tray was served at 8:50 AM. In the presence of a US FOIA (b)(6), surveyor #2 recorded the following food temperatures: Oatmeal: 148.5 F 2 Pancakes: *114.3 F Sausage: *111.7 F Coffee: 154 F 4- ounce Orange Juice: 42 F *Items did not meet "Temperature Standards" per the "Test Tray" form.	F 804	reviewed for food temperatures. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. " All residents monitored for any adverse effects with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " The Regional Director of Food Services re-educated the US FOIA (b)(6) [redacted] and all dietary staff on Policy and Procedures related to proper hot and cold food temperatures. " The Regional Director of Food Services re-educated the US FOIA (b)(6) [redacted] and all Dietary staff on proper use of facility base heater and plate warmer equipment prior to each meal service. " Director of Nursing -re-educated all nursing staff regarding the importance of delivering meal trays to residents as soon as the meal delivery cart is delivered to the unit. Measures or systemic changes to ensure that the deficiencies will not recur: " The Food Service Director/Designee will conduct compliance audits on hot and cold food temps. " The Food Service Director/Designee will audit 3 trays for proper temperature, two-times per week x4 weeks, and then 3 trays for proper temperature two-times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 804	Continued From page 48 On 01/31/24 at 8:00 AM, the surveyor entered the kitchen and observed the meal tray line was in progress. The [redacted] was on the tray line and was serving the hot food items, with the [redacted] opposite of the [redacted] preparing the trays. During the observation, the surveyor observed that pancakes were being served. The surveyor asked the [redacted] what the hot food temperatures should be when the food reached the resident and he stated, "no less than 145 degrees [Fahrenheit]," and the temperatures were documented on the "Test Tray" form. On 01/31/24 at 8:06 AM, the surveyor reviewed the "Test Tray" form which revealed "Temperature Standards" Hot Entree: 130 F, Hot Beverage: 150 F, Juice: 50 F, Cold Beverage 45 F. On 02/01/24 at 12:32 PM, surveyor #1 interviewed the [redacted] regarding the "Temperature Standards" on the "Test Tray" form. The [redacted] confirmed to surveyor #1 that the "Temperature Standards" were the temperatures that the foods should be when the meals were served to the residents. The Test meal/Tray Audit Policy, dated 01/01/2024 revealed A test meal or tray audit will be conducted as deemed necessary to ensure proper temperatures and acceptable quality of all foods served.	F 804	Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	
F 812 SS=F	NJAC 8:39-17.4(a)2 Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		2/21/24

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 02/09/2024

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F 812	Continued From page 49 §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 document review it was determined that the facility failed to ensure a) the kitchen environment and equipment was maintained in a clean and sanitary manner, b) all food items were labeled with a use by date, and c) staff practiced appropriate hand hygiene during meal service to prevent the potential spread of food borne illness. The deficient practice was evidenced by the following: On 01/29/24 at 9:24 AM, the surveyor completed an initial tour of the kitchen with the US FOIA (b)(6) and the US FOIA (b)(6) and observed the following: 1. The walk-in refrigerator unit identified as the "cold cut box" had debris and crumbs on the floor underneath the racks. The surveyor asked when the box was cleaned and the US FOIA (b) stated, "not as often as it should." The door gasket was visibly	F 812	Residents affected by deficient practice: The facility failed to ensure a) The kitchen environment and equipment was maintained in a clean and sanitary manner, b) all food items were labeled with a use by date, and c) staff practiced appropriate hand hygiene during meal service to prevent the potential spread of food borne illness. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. " All residents were monitored for any adverse effects with none noted. What corrective action will be accomplished for those residents affected by the deficient practice:	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 812	Continued From page 50 soiled and ripped. 2. The walk-in freezer unit had ice buildup by the door and the gasket was ripped. 3. The bread rack contained a package of rye bread that was dated with an expiration date of 01/22/24, and there was an unsealed package of hot dog rolls. The US FOIA discarded the items and stated, "that's garbage". 4. A bag of rice and a bag of breadcrumbs were stored inside their bags, in a bin with crumbs on the bottom of the bin. 5. The wall by the affixed knife rack was soiled and two of the knives, identified as clean, were soiled. 6. Clean utensils, were hung directly next to the hand washing sink and the metal spoon and ladle had visible debris on them. On 01/31/24 at 8:00 AM, the surveyor entered the kitchen and observed the meal tray line was in progress. The US FOIA (b)(was on the tray line and was serving the hot food items at that time, with the US FOIA opposite of the US FOIA (b)(preparing the trays. During the observation, the surveyor observed that pancakes were being served and the surveyor asked the US FOIA (b)(what the hot food temperatures should be when the food reached the resident. The US FOIA (b)(stated , "no less than 145 degrees [Fahrenheit]." The surveyor then continued to observe the ongoing tray preparation on the tray line. The US FOIA (b)(was observed placing oatmeal by a ladle, utilizing his gloved hands, into a Styrofoam cup and then placed it on a plate. Then, without using a utensil, or first removing his	F 812	" The walk-in refrigerator unit cold cut box was thoroughly cleaned on 1/29/2024. " The ice buildup by the door in the walk-in freezer was addressed. " The package of rye bread that was dated 1/22/2024 and the unsealed package of hot dog rolls were discarded on 1/29/2024. " The bag of rice and breadcrumbs were discarded on 1/29/2024. " The wall by the affixed knife rack was cleaned and the two knives identified were also cleaned. " The clean utensils were removed from the hand washing sink area and the metal spoon and ladle were cleaned. " All dietary staff were re-educated on facility policy and procedure related to food labeling and dating. " All dietary staff and the US FOIA (b)(6) were re-educated on the Handwashing/Hand Hygiene, Cleaning Policies. Measures or systemic changes to ensure that the deficiencies will not recur: " Food Service Director/Designee will conduct compliance audits of the identified kitchen areas for cleanliness, and to ensure that all foods are labeled/dated properly. Also, that staff is properly utilizing the Handwashing/Hand Hygiene protocols. " The Food Service Director/Designee will conduct three audits weekly x4 weeks, then monthly x 2 months. The audits will ensure that all staff are following the Handwashing/Hand hygiene policy as required. The Food Service Director	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 812	Continued From page 51 gloves and performing hand hygiene, he proceeded to pick up two pancakes with his gloved hands, and then placed them on the resident meal plate. The surveyor observed that there was no serving utensils inside the pan of pancakes. The US FOIA (b)(6) then touched a pink towel that was in front of the steam table with his gloved hands, and then turned around and opened the refrigeration unit that was behind him and used his gloved hand and removed an item. The US FOIA (b)(6) without first performing hand hygiene, continued to pick up two more pancakes with the same gloved hands. The US FOIA (b)(6) then turned around and opened the hot box that was behind him, using the handle with the same gloved hands, and removed an omelet, closed the hot box, and then placed the omelet on a resident meal plate. Then, without performing hand hygiene, or removing the gloves, the US FOIA (b)(6) picked up two more pancakes with his gloved hands and placed them on a resident meal plate. At 8:04 AM, the surveyor asked the US FOIA (b)(6) if he should go back and forth and open and close doors and pick up pancakes with the same gloved hands, and he acknowledged he should not. The surveyor asked the US FOIA (b) who also observed the US FOIA (b)(6) utilizing gloved hands to complete different tasks, then pick up food with the same gloved hands and plate the food. The US FOIA (b) stated that food should not be touched with gloved hands. On 02/02/24 at 8:42 AM, in the presence of the survey team, the surveyor conducted an interview with the US FOIA (b)(6)). The surveyor informed the US FOI of the observations regarding the meal service that occurred on 01/31/24. The surveyor asked the US FOIA if it was acceptable to touch foods directly with gloved hands, and then	F 812	and/Designee will conduct three audits weekly x4 weeks, then monthly x2 months to ensure that food preparation equipment and utensils are clean and stored away from the hand washing sink area. The Food service Director/Designee will conduct three audits weekly x4 weeks, then monthly x2 months to ensure that all foods are dated and labeled per policy as required. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 812	Continued From page 52 touch other non food items and continue to touch food with the same gloved hands. The [redacted] stated "no, that is not acceptable" and the staff was trained to "not do that." The Handwashing/Hand Hygiene Policy, Adopted 11/2018 revealed "This facility considers hand hygiene the primary means to prevent the spread of infections". 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 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. The Cleaning Policy, Updated 01/2023 revealed it is the responsibility of all staff to maintain sanitary standards in their areas and where needed per food service director. Fod Service Director: Execute daily sanitation audit to find deficient areas in kitchen and assign daily tasks to staff. Audit all staff tools from previous day. The Dining Service Inc., Dating Policy dated 01/01/2024 revealed "Follow manufacturers expiration date on all un-opened products. All fresh and frozen foods must be dated with date it was received into the kitchen.	F 812		
F 865 SS=F	NJAC 8:38-17.2(g) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program.	F 865		2/21/24

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 02/09/2024

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F 865	Continued From page 53	F 865		

Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must:

§483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;

§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 865	Continued From page 54	F 865		

facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

§483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.

§483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing;
§483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

§483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 865	Continued From page 55 provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review it was determined that the[US FOIA (b)(6)] failed to ensure that the facility self-identified areas for improvement and followed the facility policy to ensure the Quality Assurance and Performance Improvement (QAPI) Program reviewed adverse events. This deficient practice occurred for 1 of 1 [NJ Exec Order 26.4b1] and was evidenced by the following: Refer to 610G, 761E, 880E On 02/02/24 at 8:55 AM, the surveyor interviewed the [US FOIA (b)(6)] in the presence of the survey team, regarding what the process was to determine	F 865	Residents affected by deficient practice: Licensed Nursing Home Administrator failed to ensure that the facility self-identified areas for improvement and followed the facility policy to ensure the Quality Assurance and Performance Improvement Program reviewed adverse events such as [NJ Exec Order 26.4b1] Identify those individuals who could be affected by the deficient practice. " All residents have the potential to be affected. " All residents monitored for any adverse effects with none noted.	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 865	Continued From page 56 what became a QAPI. The [US FOIA (b)(6)] stated "I haven't done anything because I have [NJ Exec Order 26.4b1] ". The [US FOIA (b)(6)] stated he had a meeting with his staff and the surveyor inquired as to what QAPIs were in place already. The [US FOIA (b)(6)] stated that he started looking through the old [US FOIA (b)(6)] QAPI documents, but he did not get through all of it. The surveyor asked the [US FOIA (b)(6)] how he established what is a [NJ Exec Order 26.4] concern and reviewed at QAPI, including [NJ Exec Order 26.4b1] like a reportable event (RE). The [US FOIA (b)(6)] stated he was unaware if adverse events were tracked at the QAPI and that the US FOIA (b)(6) would know that information. When asked who was responsible for the QAPI process, the [US FOIA (b)(6)] stated he took responsibility for the QAPI. The surveyor then asked if there was anything that would be considered "[NJ Exec Order 26.]" and he stated, "[NJ Exec O] I am sure that is why they would put it in QAPI". On 02/02/24 at 9:03 AM, the surveyor asked the [US FOIA (b)(6)] to inform the surveyor regarding all the active QAPIs. The [US FOIA (b)(6)] stated his current QAPIs included the following: 1. Housekeeping- mechanical lift pads were getting ripped off and torn. 2. Kitchen- cooks not logging temperature log right before they served the meals. 3. Therapy- orders. 4. Activities- related to picture consents. 5. Infection prevention- regarding water cups in rooms. 6. Material Data Set (MDS)- care plan reviews not signed off. 7. Business office- authorization forms and accounts resident accounts. 8. Nursing- Activity of Daily Living completion logs and completed documentation.	F 865	What corrective action will be accomplished for those residents affected by the deficient practice: " US FOIA (b)(6) were re-educated on facility Quality Assurance and Performance Improvement-Feedback, Data and Monitoring policy by the Regional Administrator,including any significant events, fracture of unkown origin. " Management Team, and remaining staff re-educated on facility Quality Assurance and Performance Improvement policy, procedure, and practice by Administrator and Director of Nursing. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee to conduct compliance audits related to tracking and measuring performance of environmental concerns, resident care related concerns and significant incidents; systematically analyzing underlying causes of system quality deficiencies and establishing goals and thresholds to be monitored ongoing or until compliance is met. " Administrator/designee will monitoring all Quality Assurance and Performance Improvements, one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 865	Continued From page 57 On 02/02/24 at 9:10 AM, the US FOIA (b)(6) stated he has not yet had a QAPI meeting. The surveyor inquired how the US FOIA (b)(6) determine what is brought QAPI, and the US FOIA (b)(6) stated "maybe a grievance" and we see if there are any issues with nursing. On 02/02/24 at 9:15 AM, the US FOIA (b) joined the interview with the US FOIA (b)(6) The surveyor asked the US FOIA (b) what her role was in QAPI process. The US FOIA (b) stated if we see any issues, and the US FOIA (b)(6) stated with nursing we would use a root cause analysis and education. The surveyor asked the US FOIA (b)(6) what a root cause analysis was and he stated, we do an investigation, "in a sense". On 02/02/24 at 9:17 AM, the surveyor asked the US FOIA (b) if the current nursing QAPI plans included the folowing concerns that were identified during the survey: -Hand Hygiene, she responded- "no". -Medication Receipt, she responded "no". -Anything related to catheter use, she responded "no". On 02/02/24 at 9:17 AM, the surveyor asked the US FOIA (b) if she brought any significant events/ or Reportable Events to QAPI and she stated, "no". On 02/02/24 at 9:58 AM the surveyor, in the presence of the survey team, interviewed the US FOIA (b)(6) regarding Reportable Events and the Quality Assurance and Performance Improvement process. The surveyor inquired about any recent NJ Exec Order 26.4b1 events and the US FOIA (b) informed the surveyor about Resident #257 who NJ Exec Order 26.4b1 The surveyor inquired further about what was completed regarding the incident,	F 865	the need for continued submission and reporting.	

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F 865	Continued From page 58	F 865		

and the [redacted] stated the resident [redacted] and "I just did an investigation" and then provided the surveyor with a copy of a Reportable Event (a required document for a [redacted] that must be submitted to the Department of Health). The surveyor asked the [redacted] if she completed a root cause analysis regarding the [redacted] The [redacted] stated, "no, that is QAPI", I just did an investigation, and stated the [redacted].

The Qulaity Assurance and Perforamnce Improvement (QAPI) program-Feedback, Data and Monitoring policy revealed: The QAPI program is based on the collection information obtained from date, self-assessment and systems of feedback. Information is collected, evaluated and monitored by the QAPI committee.Policy Interpretation and Implementation: 1. Information obtained about the quality of care and services delivered to residents is evaluated and monitored by the QAPI committee in order to identify problems that are high risk, high volume or problem prone and to guide decisions regarding opportunities for improvement. 2. The QAPI process focuses on identifying systems and processes that may be problematic and could be contributing to avoidable negative outcomes related to resident care, quality of of life, resident safety, resident choice or resident autonomy, and on making a good faith effort to correct or mitigate these outcomes.

The Quality Assurance and performance Improvement (QAPI) Program, Reviewed 5/2023 revealed: The facility shall develop, implement, and maintain an ongoing, facility-wide, data driven QAPI Program that is focused on

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 865	Continued From page 59 indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI Program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. Authority, 3. The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory requirements. Systematic Analysis and Systemi Action: Root Cause Analysis is used to fully understand systemic problems, causes of the problems, and implications for change. Teams are formed to identify the root cause and contributing factors of an issue employing the process of the Five Whys of root cause analysis. A thorough understanding of all possible causes or factors impacting the area of focus is critical to identify actions that maybe implemented or systemic changes that my be needed to employ for improvement. NJAC 8:39-27.1(a)	F 865		
F 880 SS=E	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	F 880		2/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 60	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, 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

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F 880	Continued From page 61 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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 observation, interview, record review, and review of facility documentation, it was determined that the facility failed to a.) properly don (put on) a Personal Protective Equipment (PPE) gown used to mitigate the spread of NJ Exec Order 26.4b1 for Resident #306, 1 of 4 residents reviewed for NJ Exec Order 26.4b1 , b.) maintain appropriate NJ Exec Order 26.4b1 control practices for 2 residents (Resident #106 and #306) with an NJ Exec Order 26.4b1, and c.) to perform appropriate hand hygiene during meal service on 1 of 3 units (NJ Exec NJ E for two meals. This deficient practice was evidenced by the following: a.) On 01/30/24 at 8:21 AM, Surveyor #1 observed a staff member outside of Resident #306's room. The surveyor observed signage posted at the door for NJNJ Exec Order 26.4b1 which included but was not limited to; providers and staff must also: wear gloves and gown for the following NJ Ex Order 26.4(b)(1) resident care activities which included NJ Exec Order 26.4 and NJ Exec Order 26.4b1 The surveyor observed a bin full of	F 880	Residents affected by deficient practice: The facility failed to a.) properly don (put on) a Personal Protective Equipment gown used to NJ Exec Order 26.4b1 for Resident #306, 1 of 4 residents reviewed for NJ Exec Order 26.4b1 , b.) maintain appropriate NJ Exec Order 26.4b1 practices for 2 residents (Resident #106 and #306) with an NJ Exec Order 26.4b1, and c.)to perform appropriate hand hygiene during meal service on 1 of 3 units (Unit NJ E for two meals. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. " Residents #106 and #306 were monitored for any NJ Exec Order 26.4b1 " The US FOIA (b)(6) was immediately re-educated on 1/30/2024 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 _____	C 02/09/2024

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F 880	Continued From page 62 available PPE. At that time, a staff member approached Resident #306's room. The staff member was wearing a surgical mask and donned a PPE gown. The staff member failed to secure the PPE gown with the ties around her back. The staff member entered the room and explained to the resident she was there to help her get dressed and work with her. The staff member was in NJ Exec Order 26.4b1 with the resident, the resident's bed, and kneeled down with the PPE gown freely flowing open and in NJ Exec Or with the resident and the resident's environment. At 01/30/24 at 8:28 AM, Resident #306's US FOIA (b)(6) was in the hall outside of the resident's room. The US FOIA stated that the resident was on NJ Exec Order 26.4b1 because he/she had a NJ Exec Order 26.4b1 The US FOIA stated that to provide care, staff were to apply gloves and PPE. When asked about how to apply the PPE gown, the US FOIA replied to put the hole over the head, slide arms through, and tie it in the back in order to cover the entire body. She stated it needed to cover the staff completely in order to prevent infection on the staff and being transferred to other residents. The US FOIA knocked on the door, opened the door and was able to acknowledge that the staff member did not wear the PPE gown properly to prevent the spread of NJ Exec Order 26.4b The US FOIA and surveyor observed the staff member in NJ Exec Order 26.4b1 with the resident and assisting the resident with NJ Exec Order 26.4b The resident had his/her hands in the air and the US FOIA (b)(6) was actively assisting him/her NJ Exec Order 26.4b1. On 01/30/24 at 8:34 AM, the staff member exited	F 880	proper donning and doffing protocols and on the Enhanced Barrier Precautions Policy and Procedure. " The NJ Exec Order 26.4b1 of resident #106 was adjusted so it does not directly touch the floor. Also, the NJ Exec Order 26.4b by staff for resident #306. " Certified Nursing Assistant #1 and Certified Nursing Assistant #2, the US FOIA (b)(6), and the six staff members mentioned were educated on proper Handwashing/Hand Hygiene. What corrective action will be accomplished for those residents affected by the deficient practice: " All staff will be re-educated on proper donning and doffing protocols and on the Enhanced Barrier Precautions Policy and Procedure. " All nursing staff will be re-educated on Catheter Care, Urinary Policy, and Procedure. " All facility staff were re-educated in the Handwashing/Hand Hygiene policy. Measures or systemic changes to ensure that the deficiencies will not recur: " Director of Nursing/Designee to conduct compliance audits. " The Director of Nursing/Designee will conduct three audits weekly x4 weeks then monthly x2 months. The audits will be in the form of observations of staff members performing hand hygiene when indicated and donning and doffing of PPE while providing care and/or entering/exiting patient rooms who require Enhanced Barrier Precautions. Also, the	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 880	Continued From page 63 the room and was interviewed at that time. The staff member identified herself as the US FOIA (b)(6) [redacted]. She stated the resident was on NJ Exec O[redacted] because of an NJ Exec Order 26.4b1. She further stated that she was aware she had her PPE gown on incorrectly and that she "just forgot". She stated that the importance of wearing the PPE was to ensure her whole body was covered to prevent NJ Exec Order 26.4b [redacted] A review of the Admission Record revealed that Resident #306 was recently admitted with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the Order Summary Report revealed an order dated NJ Exec Order 26[redacted], NJ Exec Order 26.4b1 [redacted] & tx [treatment] 4-6 x/wk [times a week] x NJ Exec Order 26[redacted] or as tolerated for NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec Order 26.4b1, NJ Exec [redacted], pt. [patient]/caregiver education, d/c [discharge] planning. A review of the resident-centered on-going care plan included but was not limited to; a focus area of ADL [activities of daily living] NJ Exec Orde[redacted] related to NJ Exec Order 26.4b1 [redacted] with interventions which included staff assistance which included NJ Exec Order 26[redacted] and NJ Exec Order 26.4b[redacted]. A focus area requires enhanced NJ Exec Order 26.4b1 [redacted] Interventions included but were not limited to; clear signage on the door indicating the type of NJNJ Exec Order 26.4b1 and required PPE. NJ Exec [redacted], signage should also clearly indicate the NJ Exec Order 26.4b1	F 880	Director of Nursing/Designee will conduct three audits weekly x4 weeks then monthly x2 months. The audits will be to ensure that urinary drainage dignity bag is not touching the floor and the drainage bag is capped as required. " Director of Nursing/Designe will audit one-time weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 880	Continued From page 64 care activities that require the use of gown and gloves. A review of the NJ Exec Order 26.4b1 Summary of Daily Skilled Services, dated NJ Exec Order 26.4b1, included but was not limited to; NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 . On 01/30/24 at 9:22 AM, the US FOIA (b)(6) [redacted] stated that the US FOIA (b)(6) [redacted] had been educated in donning and doffing (removing) PPE. The US FOIA (b)(6) stated that it was important to wear PPE correctly to protect the staff members clothes and prevent them from NJ Exec Order 26.4b1 to other residents. A review of the facility provided In-Service, "Droplet Precautions, Contact Precautions, EBP (Enhanced Barrier Precaution), hand hygiene and PPE Review", dated 12/26/23, included the Director of Therapy had attended and was educated. The education material included but was not limited to; clinical competency validation critical elements: Gowning 5. Pull gown on, making sure it completely covers clothing/torso. If it does not, use 2 gowns. Don the first gown with opening to the front. Use the second gown over the first, with opening to the back. The facility included the competency that the Director of Therapy had demonstrated and passed, dated 12/26/23.	F 880		

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	315274	A. BUILDING _____ B. WING _____	C 02/09/2024

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F 880	Continued From page 65	F 880		

A review of the facility provided, "Enhanced Barrier Precautions Policy and Procedure", revised 7/22/22, included but was not limited to; Purpose: the implementation of EBP will reduce the transmission of resistant organism by employing targeted gown and glove use during high contact resident care activities. Policy: EBP will be implemented for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status. Enhanced Barrier Precautions "expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... . Nursing home residents with .... Indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs."

b.) On 01/29/24 at 10:25 AM, Surveyor #2 observed Resident #106 sitting in a wheelchair in the room with a NJ Exec Order 26.4b1 attached to the resident's NJ Exec Order 26.

On 01/29/24 at 11:01 AM, Surveyor #2 returned to the room and found the resident was NJ Exec Order and NJ Exec O and informed the surveyor he/she just returned from NJ Exec Order 26.4b1 and was NJ Exec Or The surveyor asked for the resident's consent to check the bathroom. The surveyor then observed the NJ Exec Order 26.4b1 stored in a NJ Exec Order 26.4b1 on the rail in the bathroom. The NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1.

On 01/31/24 at 12:45 PM, Surveyor #2 entered the room and observed Resident #106 in bed. Surveyor #2 observed the NJ Exec Order 26.4b1

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 02/09/2024

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F 880		F 880		

Continued From page 66

NJ Exec Order 26.4b1 inside NJ Exec Order 26.4b1 rested in direct contact on the floor. The surveyor left the room and informed the JS FOIA who was at the nurses station of the observation. The JS FOIA went to the room, adjusted the bed and exited the room.

On 01/31/24 at 1:15 PM, during an interview with the JS FOIA (D the JS FOIA stated that the NJ Exec Order 26.4b1 should not be rested in direct contact on the floor to prevent NJ Exec Order 26.4b

On 02/01/24 at 11:30 AM, Surveyor #2 observed the resident in bed. The NJ Exec Order 26.4b1 was noted in direct contact with the floor. The surveyor escorted the JS FOIA to the room and she confirmed the surveyor's observations and NJ Exec Order 26.4b1 the bed.

A review of the Admission Face Sheet (a summary assessment) reflected that Resident #106 was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 The Admission Minimum Data Set (MDS) dated NJ Exec Order 26.4b, reflected that Resident #106 had NJ Exec Order 26.4b1. Resident #106 scored NJ E /15 on the Brief Interview for Mental Status (BIMS). The Comprehensive Care Plan dated NJ Exec Order 26.4b, reflected that Resident #106 had an NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1. The Order Summary Report dated NJ Exec Order 26.4, reflected an order to render NJ Exec Order 26.4b1 every shift and as needed.

An interview with the JS FOIA on 01/29/24 at 11:40 AM, revealed that the Certified Nursing Assistant (CNAs) were responsible to provide NJ Exec Order 26.4b1 to the residents. The JS FOIA stated, the CNAs would

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 02/09/2024

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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F 880	Continued From page 67	F 880		

NJ Exec Orde the NJ Exec Order 26.4b1, and recorded and reported the NJ Exec Order 26.4b1 to the nurse. The US FOIA added that during the day the CNAs would switch the NJ Exec Order 26.4b1 to a NJ Exe

On 02/01/24 11:50 AM, Surveyor #2 interviewed the US FOIA (6) regarding the storage of the NJ Exec Orde. The US FOIA (6) stated that the NJ Exec Order 26.4b1 should be NJ Exec Order 26 to prevent NJ Exec Order 26.4b

A review of the Progress Notes dated NJ Exec Order 26.4b timed 11:36 PM, revealed that the NJ Exec Order 26.4b1 was noted with NJ Exec Order 26.4b1 The physician was informed and ordered a NJ Exec Order 26.4b1 and NJ Exec Order 2 and NJ Exec Order 26.4b1 to rule out a NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 collected on NJ Exec Order 26.4b was NJ Exec Order 26.4b1 Resident #106 was diagnosed with a NJ Exec Order 26.4b1

A review of the Admission Face Sheet revealed that Resident #306 was admitted to the facility with diagnoses which included but were not limited to: NJ Exec Order 26.4b1 The Admission Care Plan dated NJ Exec Order 26.4b, reflected that Resident #306 had a focus for NJ Exec Order 26.4b1 related to NJ Exec Orde The goal was the NJ Exec Order 26.4b1 will be NJ Exec Order 26.4b1. Interventions included: NJ Exec Order 26.4b1, monitor vital signs, obtain and monitor NJ Exec Order 26.4b1 as ordered... Resident #306 had also a focus for NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1:

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 02/09/2024

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 880	Continued From page 68	F 880		

NJ Exec Order 26.4b1 The goal was that Resident #306 will have no ill effects related to the NJ Exec Order 26.4b1 . Interventions included: Clear signage must be posted on the door or wall outside of the resident room. Educate the resident /family and care giver on the importance of handwashing. The care plan did not provide the direct care staff directives regarding storage of NJ Exec Order 26.4b1 bag to prevent NJ Exec Order 26.4b

On 01/30/24 at 9:30 AM, Surveyor #2 observed Resident #306 sitting in the room with NJ Exec Order 26. attached to the NJ Exec Order 26.4. The surveyor asked the resident if she could checked the bathroom. The resident agreed. The surveyor went to the bathroom and observed the NJ Exec Orde stored in a plastic NJ Exec Order 26.4b1 in the bathroom. The NJ Exec Order 26.4b1 was not NJ Exec Order 26

On 01/31/24 at 9:40 AM, Surveyor #2 observed Resident #306 sitting in a wheelchair in the room with the NJ Exec Order 26.4b1 secured to the NJ Exec Order 26. The surveyor went to the bathroom and observed the NJ Exec Order 26.4b1 stored in a NJ Exec Order 26.4b1 on the rail in the bathroom. The NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1. The surveyor left the room and escorted the US FOIA to the bathroom. The US FOIA donned gloves and retrieved the NJ Exec Order 26.4b1 from the plastic bag in the bathroom. The NJ Exec Order 26.4b1 was noted with NJ Exec Order 26.4b1, the NJ Exec dated NJ Exec Orde, and the NJ Exec Order 26.4b1 was not NJ Exec Order 26. The nurse stated that the NJ Exec should be NJ Exec Orde and NJ Exec Order 26 to prevent NJ Exec Order 26.4b

On 01/31/24 at 9:52 AM, Surveyor #2 interviewed the US FOIA who cared for the resident. She

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 02/09/2024

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 880	Continued From page 69	F 880		

acknowledged that she cared for Resident #306 that morning and disposed of the NJ Exec Order 26.4b1 in the receptacle bin. The surveyor went to the bathroom with the US FOIA (b) and we both observed the NJ Exec Order 26.4b1 stored in the plastic NJ Exec Order 26.4b1 in the bathroom. When asked regarding NJ Exec Order 26.4b1, the US FOIA (b) demonstrated to the surveyor how she switched the NJ Exec Order 26.4b1 to the NJ Exec . She did not acknowledged that the NJ Exec Order 26.4b1 to be disinfected before being connected.

On 01/31/24 at 10:12 AM, Surveyor interviewed the US FOIA (b)(6) regarding NJ Exec Order 26.4b1 care. The US FOIA (b)(6) revealed that the CNAs were to clean and observe the NJ Exec Order 26.4b1. The US FOIA (b)(6) added that the residents would have the NJ Exec Order 26.4b1 while in bed, but the NJ Exec Order 26.4b1 was being used during the day when the resident was up and NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 was NJ Exec Order 26.4b1 and as needed. The CNAs were to wash their hands, explain the procedure to the resident, don gloves, cleanse the NJ Exec with an alcohol swab and switch over to the NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 was to be rinsed of any NJ Exec Order 26.4b1, stored in a plastic bag in the bathroom with the NJ Exec Order 26.4b1. The US FOIA (b)(6) stated that she was aware of the concerns, and she would consult with the US FOIA (b)(6) and identify when the last in-service on NJ Exec Order 26.4b1 care was done.

On 01/31/24 at 11:16 AM, the US FOIA (b)(6) provided an in-service sign-in sheet for 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 _____	C 02/09/2024

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 880	Continued From page 70 NJ Exec Order 26.4b1 policy and procedure dated NJ Exec Order 26.4b Both CNAs involved attended the in-service education. On 02/02/24, Surveyor #2 reviewed the facility's Policy/Procedure: "Catheter Care, Urinary" with a revision date of 08/2022 updated 1/2023, which included but was not limited to; Purpose The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Infection Control Use aseptic technique when handling or manipulating the drainage system Be sure the catheter tubing and drainage bag are kept off the floor. Cleaning drainage bags: Disconnect the drainage bag from the catheter; replace with a clean bag. Use a soft, plastic squirt bottle to rinse the used bag with tap water and drain. Cleanse the drainage bag with water' Drain the water, and allow the bag to air dry with the clam open. Use bleach that is not scented or concentrated. When using a water, use gloves, aprons, and goggles to protect from fumes and irritation caused by contact. After cleansing, air-dry the bag. After cleaning, cap drainage bag tubing between uses and disinfect the end of the tubing with alcohol before reconnecting it to the catheter. On 02/02/2024 at 1:14 PM, the survey team met with the administrative staff and informed them of	F 880		

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 02/09/2024

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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F 880	Continued From page 71	F 880		

the findings. On 02/05/24, the facility provided in-service education done on NJ Exec Order 26.4b1 [redacted] care. No additional information was provided.

NJ Exec Order 26.4b1

c. On 01/31/24 from 7:31 AM to 7:49 AM, the surveyor observed the breakfast meal delivery on Unit [redacted]. The meal trays were distributed from a meal cart and the surveyor observed two Certified Nurse Aides (CNA #1 and #2) distribute meals. CNA #1 was observed, wearing gloves in the hallway, then removed a meal tray from the meal cart. She then brought the meal tray to Room #309, and proceeded to set the meal tray up for the resident, then without first removing her gloves and performing hand hygiene, she repeated the same observation in Room #308, and #307 wearing the same gloves. The surveyeyor then interviewed CNA #1 regarding what should be done between the meal trays and setting up the residents. CNA #1 stated she knows she needed to use hand hygine (HH), howerver, there was no HH available in the hallway for the staff to use. The surveyor then interviewed the US FOIA (b)(6) regarding the surveyor's observations. The [redacted] stated that "they should have had hand sanitizer on them" and showed the surveyor a bottle that she had in her pocket, and stated hand sanitizer was also located behind the nurses station.

On 01/31/24 at 12:09 PM, during the lunch meal service in the Unit [redacted] activities room, the surveyor observed six staff members deliver lunch trays to 13 residents without performing hand hygiene between residents. The surveyor did not observe any hand gel readily available to the staff in 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 _____	C 02/09/2024

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 880	Continued From page 72 activities room. The surveyor observed a CNA, using hand hold assistance, [NJ Exec Order 26.4b1] an unsampled resident and assisted the resident to a chair at a table. CNA#1 then went to the food cart and obtained the resident's lunch tray, placed it in front of the resident, removed the plate and juices from the tray and placed them on the table. CNA#1 returned the tray to the food cart. CNA#1 did not perform hand hygiene before proceeding to assist another resident. The surveyor observed CNA#2 assist an unsampled resident by adjusting his/her legs onto the wheelchair [NJ Exec Order 26.4]. CNA #2 then assisted another resident set up their juice on the table without performing hand hygiene between residents. On 01/31/24 at 12:17 PM, the surveyor interviewed an [US FOIA (b)(6)]) who stated that during lunch meal he would help pass out the lunch trays, make sure the diets are correct and that it was the correct lunch tray for the right resident. When asked if hand hygiene should be performed between residents, the [US FOIA] stated "I did not do it today because we were serving fast. I normally do but not today." On 01/31/24 at 12:21 PM, the surveyor interviewed CNA #1 who stated "you're supposed to use hand hygiene between residents when serving trays but we don't have any. I know the rules but we don't have hand gel." The Handwashing/Hand Hygiene Policy, Adopted 11/2018 revealed "This facility considers hand hygiene the primary means to prevent the spread of infections". 2. All personnel shall follow the handwashing/hand hygiene procedures to help	F 880		

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 73 prevent the spread of infections to other personnel, residents, and visitors. 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. NJAC NJAC 8:39-19.4 (a) (1)(5)	F 880		
F 919 SS=E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of documentation, it was determined that the facility failed to ensure all residents had a call bell available and within reach to alert staff for assistance. This deficient practice was identified for 2 of 25 residents reviewed for call bells (Resident 100 and Resident #6) on 2 of 3 resident units (Unit #[redacted] and #[redacted] and was evidenced by the following: On 01/29/24 at 11:40 AM, while in the hallway on the Unit #[redacted] Surveyor #1 heard a staff member calling on the nurse to assist with Resident #106. The surveyor followed the nurse and observed Resident #106 sitting on a [redacted] and had	F 919	Residents affected by deficient practice: The facility failed to ensure all residents had a call bell available and within reach to alert staff for assistance. This deficient practice was identified for 2 of 25 residents reviewed for call bells (Resident #100 and Resident #6) on 2 of 3 resident units (Unit #[redacted] and #[redacted] Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected. " The affected residents #100 and #6 were checked to ensure that they have	2/21/24

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 919	Continued From page 74 attempted to NJ Exec Order 26.4b1 . The resident stated that he/she needed to go the NJ Exec Order 26.4b1 The surveyor did not observe a call bell located near the resident. On 01/29/24 at 12:11 PM, Surveyor #1 observed the resident in a NJ Exec Order 26.4b1 at the nurse's station. The surveyor attempted to interview the resident. The resident NJ Exec Order 26.4b1 " The surveyor returned to the room and observed the call bell was behind the dresser at the adjacent corner of the room. On 01/30/24 at 8:20 AM, Surveyor #1 observed Resident #100 in bed. The bed was in a NJ Exec with a NJ Exec Order 26.4b1 on the right side of the bed. The call bell was noted in the same position, behind the dresser at the adjacent corner of the room. The call light was not accessible to the resident. On 01/30/24 at 9:00 AM, Surveyor #1 entered the room with the US FOIA (b)(6) Surveyor #1 observed Resident #100 was awake in bed, and there was no call bell attached to the wall or within reach of the resident. The surveyor inquired to the US FOIA if she could show and activate the call bell for Resident #100. The nurse could not locate the call bell. The call bell was not attached to the bed. The nurse looked into the room and reached for the call light that was behind the dresser in the room. The nurse stated that the call light should be accessible and attached to the resident's blanket. On 01/30/24 at 9:12 AM, Surveyor #1 asked the Unit # NJ US FOIA (b)(6) how the resident's care was	F 919	working call bells and they are within reach. " A facility wide audit was conducted to ensure that all other residents had call bells within reach while in bed. All residents monitored for any adverse effects with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: " The Director of Nursing/Designee re-educated Nursing/Therapy staff regarding ensuring that all residents have a working call bell, and that the device is within reach every shift. Measures or systemic changes to ensure that the deficiencies will not recur: " Maintenance Director/Designee to conduct compliance audits to ensure that the residents have a working call bell, and that the device is within reach. " Maintenance Director/Designee will be checking three random patient rooms weekly x4 weeks then two times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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 02/09/2024

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 919	Continued From page 75	F 919		

communicated to the direct care staff. The [redacted] revealed that in the morning the nurses would give report to the Certified Nursing Assistant (CNA). The surveyor then inquired regarding Resident #100's care. The [redacted] stated that Resident #100 was [redacted], had [redacted], and that all needs must be [redacted] The [redacted] stated that Resident #100 can activate the call bell and the call bell should be within reach.

On 01/30/24 at 11:19 AM, Surveyor #1 reviewed Resident #100's medical record. The Admission Record revealed that Resident #100 was admitted to the facility with diagnoses which included but were not limited to: [redacted] The Admission Minimum Data Set (MDS) an assessment tool used by the facility to prioritize care dated [redacted], reflected that Resident #100 had a [redacted] and scored [redacted]/15 on the Brief Interview for Mental Status (BIMS).

Review of Progress Notes dated [redacted] at 15:06 (3:06 PM), reflected that Resident #100 was [redacted] with [redacted] and required [redacted] for [redacted]. The comprehensive Care Plan dated [redacted] had a focus area [redacted] related to [redacted]. One of the goal was to place call light within reach at all times.

Surveyor #1 observed Resident #100 in bed on [redacted] at 11:40 AM, 01/30/24 at 8:20 AM, and again at 9:00 AM. The call bell was not accessible to the resident.

On 01/29/24 at 10:07 AM, Surveyor #2 was

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 02/09/2024

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 919	Continued From page 76	F 919		

interviewing Resident #6 in his/her room. Resident #6 was lying in bed with the NJ Exec Order 26.4b1 [redacted]. Resident #6 had a NJ Exec Order 26.4b1 [redacted] on the over bed table. The surveyor asked if he/she needed to use the call bell to request assistance with the NJ Exec Order 26.4b1. Resident #6 stated, "look behind me." Resident #6 next stated, "I can't use the call bell because I haven't had one in a while." Resident #6 was unable to say how long his/her call bell was missing but stated that he/she relied on asking the roommate to call when needed.

A review of the Admission Record revealed Resident #6 had diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the Annual Minimum Data Set (MDS) an assessment tool to facilitate resident care dated NJ Exec Order 26.4b [redacted], included but was not limited to; a Brief Interview for Mental Status (BIMS) of [redacted]/15 which indicated Resident #6 had NJ Exec Order 26.4b1 [redacted] Section [redacted] - NJ Exec Order 26.4b1 [redacted] and Goals revealed that Resident #6 was dependent on staff for NJ Exec Order 26.4b1 [redacted] and NJ Exec Order 26.4b1. A review of the resident centered on-going care plan included but was not limited to; a focus area of ADL (Activities of Daily Living) NJ Exec Order 26.4b1 related to NJ Exec Order [redacted] imitated NJ Exec Order 26.4b [redacted] Goals included ADL care needs will be anticipated and met. Interventions included dependent of 1 staff with NJ Exec Order 26.4b1 [redacted] extensive assistance for NJ Exec Order 26.4b1 [redacted]; extensive assist by 1 staff to [redacted] minimal assistance by 1 staff for NJ Exec Order 26.4b1; extensive assist by 1 staff for [redacted] extensive assist by 1 staff to NJ Exec Order 26.4b1 [redacted]; and encourage to use bell to call

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 02/09/2024

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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F 919	Continued From page 77	F 919		

for assistance.

On 01/29/24 at 10:09 AM, Surveyor #2 went to the Unit #[redacted] nurse's desk and asked the [redacted] to accompany the surveyor to Resident #6's room. The [redacted] looked around the room and acknowledged there was no call bell available for Resident #6. The [redacted] then stated it was important for all residents to have a call bell and that the call bell be within reach because the call bell was a " resident's lifeline". At that time, Resident #6 stated to the [redacted] and surveyor that he/she has had to rely on their roommate to call for help.

On 02/02/24 at 9:47 AM, Surveyor #2 observed Resident #6 in bed. The surveyor did not observe a call bell. The surveyor asked Resident #6 if he/she had his/her call bell and the resident shook his/her head no. The surveyor looked for the call bell and observed it at the top of the bed above the residents pillow and was out of reach of the resident.

On 02/02/24 at 9:49 AM, the [redacted] unit [redacted] accompanied Surveyor #2 to the resident's room and acknowledged the call bell was not in reach of the resident.

A review of the facility provided, "Certified Nursing Assistant" job description undated, included but was not limited to; answer resident calls promptly. Ensure a safe environment.

A review of the facility provided, "Staff Nurse" job description undated, included but was not limited to; make (at least daily) rounds to evaluate and observe the resident's physical and emotional

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 02/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 919	Continued From page 78 status and to ensure continuing quality of care. Answers call lights promptly. Ensures a safe environment. Ensures that resident who are unable to call for help are checked frequently. A review of the facility provided, "Call Lights" procedure updated 01/2023, included but was not limited to; Purpose: the light and/or sound system to alert staff to patient needs. Equipment: bedside call light with cord. Procedure: 6. Always position call light conveniently for use and within reach of the resident. 8. Check lights when providing care to ensure that cord length is appropriate, and that light is in working order. Report defective call lights promptly ..... NJAC 8:39-31.8 (9)	F 919		

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 02/09/2024

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	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, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in Certified Nursing Assistant (CNA) staffing for 14 of 14-day shifts reviewed. 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 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 (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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and	S 560	Residents affected by deficient practice: The facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by this deficient practice. " All residents 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: " The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes. " The facility will take the following measures to ensure this deficient practice does not occur. The facility will focus recruitment and retention strategies as following: identify vacant positions daily and attempt to fill positions with current	2/21/24

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

Electronically Signed | 02/21/24

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 02/09/2024

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) COMPLETE DATE
S 560	Continued From page 1 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. A review of the "Nurse Staffing Report" completed by the facility for the 2 weeks from 01/14/2024 to 01/27/2024 revealed that the facility was deficient in CNA staffing for residents on 14 of 14-day shifts as follows: -01/14/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/15/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/16/24 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/17/24 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/18/24 had 11 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/19/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/20/24 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/21/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/22/24 had 9 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/23/24 had 9 CNAs for 109 residents on the day shift, required at least 14 CNAs. -01/24/24 had 12 CNAs for 109 residents on the day shift, required at least 13 CNAs. -01/25/24 had 11 CNAs for 106 residents on the day shift, required at least 13 CNAs. -01/26/24 had 11 CNAs for 105 residents on the day shift, required at least 13 CNAs. -01/27/24 had 12 CNAs for 105 residents	S 560	CNA staff or agency; work diligently with Administrator, Director of Nursing and Corporate Recruiter to advertise, recruit and hire sufficient CNA staff; continue to develop programs to attract Nursing Assistants including sign-on bonuses', shift bonuses, etc.; work with CNA class instructors to identify potential students; promote in-house programs to increase retention of current staff. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee to conduct compliance audits on effectiveness of hiring strategies to include open CNA and Licensed Nurse positions, reporting on new hires, successful strategies-to-hire, and implementation of employee retention programs. " The duration of all audits will consist of completion one-time weekly x 4 weeks then three-times monthly x2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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 02/09/2024

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) COMPLETE DATE
S 560	Continued From page 2 on the day shift, required at least 13 CNAs. During an interview with the surveyor on 02/01/24 at 09:43 AM, the Staffing Coordinator (SC) expressed knowledge regarding the New Jersey state mandated Certified Nursing Assistant (CNA) to resident ratios. The SC stated that on the 7:00 AM-3:00 PM shift was 8:1, on the 3:00 PM-11:00 PM shift was 10:1, and on the 11:00 PM-7:00 AM shift was 14-1. NJAC 8:39-5.1 (a)	S 560		

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 _____	R-C 04/10/2024

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
{E 000}	Initial Comments	{E 000}		
{F 000}	Facility found to be in compliance INITIAL COMMENTS An onsite revisit was conducted on 4/10/2024 to verify the facility's Plan of Correction (POC) regarding the 2/9/2024 Recertification survey. The facility was found to be in compliance.	{F 000}		

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

Electronically Signed | 04/16/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	4/10/2024

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 E0004 Reg. # 483.73(a) LSC	Correction Completed 02/21/2024	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	
2/9/2024	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315274 Y1	A. Building B. Wing Y2	4/10/2024 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 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 F0610	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	02/21/2024	LSC	02/21/2024	LSC	02/21/2024
ID Prefix F0684	Correction	ID Prefix F0695	Correction	ID Prefix F0761	Correction
Reg. # 483.25	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	02/21/2024	LSC	02/21/2024	LSC	02/21/2024
ID Prefix F0804	Correction	ID Prefix F0812	Correction	ID Prefix F0865	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i)	Completed
LSC	02/21/2024	LSC	02/21/2024	LSC	02/21/2024
ID Prefix F0880	Correction	ID Prefix F0919	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(g)(1)(2)	Completed	Reg. #	Completed
LSC	02/21/2024	LSC	02/21/2024	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/9/2024	☐ 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 A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315274		4/10/2024

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 02/21/2024	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 2/9/2024	☐ 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
	061532	A. BUILDING: _____ B. WING _____	R-C 04/10/2024

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) COMPLETE DATE
S 000	Initial Comments 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: Based on review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident in Certified Nursing Assistant (CNA) staffing for 14 of 14-day shifts reviewed. 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 at N.J.S.A. 30:13-18 (the Act), which	{S 560}	Residents affected by deficient practice: The facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey. Identify those individuals who could be affected by the deficient practice: " All residents have the potential to be affected by this deficient practice. " All residents 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:	4/12/24

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

Electronically Signed | 04/16/24

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 _____	R-C 04/10/2024

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) COMPLETE DATE
{S 560}	Continued From page 1 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. A review of the "Nurse Staffing Report" completed by the facility for the 2 weeks from 03/24/2024 to 04/06/2024 for the 04/10/2024 Revisit survey revealed that the facility continues to be deficient in CNA staffing for residents on 14 of 14-day shifts. The POC did not correct the deficient practice and the facility continued to increase their census. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -03/24/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/25/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/26/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/27/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/28/24 had 11 CNAs for 118 residents	{S 560}	" The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes. " The facility will take the following measures to ensure this deficient practice does not occur. The facility will focus recruitment and retention strategies as following: identify vacant positions daily and attempt to fill positions with current CNA staff or agency; work diligently with Administrator, Director of Nursing and Corporate Recruiter to advertise, organized a bi-weekly recruitment call to review open positions and recruitment tactics, recruit and hire sufficient CNA staff; continue to develop programs to attract Nursing Assistants including sign-on bonuses, shift bonuses, perfect attendance bonuses, etc.; work with CNA class instructors to identify potential students; promote in-house programs to increase retention of current staff. Also will be having a job fair on 5/2/2024. Measures or systemic changes to ensure that the deficiencies will not recur: " Administrator/designee to conduct compliance audits on effectiveness of hiring strategies to include open CNA and Licensed Nurse positions, reporting on new hires, successful strategies-to-hire, and implementation of employee retention programs. " The duration of all audits will consist of completion one-time weekly x 4 weeks then three-times monthly x2 months.	

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 _____	R-C 04/10/2024

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) COMPLETE DATE
{S 560}	Continued From page 2 on the day shift, required at least 15 CNAs. -03/29/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/30/24 had 11 CNAs for 118 residents on the day shift, required at least 15 CNAs. -03/31/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs. -04/01/24 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -04/02/24 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -04/03/24 had 11 CNAs for 114 residents on the day shift, required at least 14 CNAs. -04/04/24 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -04/05/24 had 12 CNAs for 114 residents on the day shift, required at least 14 CNAs. -04/06/24 had 12 CNAs for 113 residents on the day shift, required at least 14 CNAs. NJAC 8:39-5.1 (a)	{S 560}	Results of audits will be reviewed at the Monthly Quality Assurance Meeting and Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
061532	A. Building B. Wing	4/24/2024

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 04/12/2024	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	
2/9/2024	☐ 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
	315274	A. BUILDING **01** B. WING _____	**02/09/2024**

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
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 02/08/2024 and 02/09/2024 Complete Care at Laurelton was found to be in noncompliance 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 Laurelton is a single story, Type V Protected building that was built in January 1, 1988. The facility is divided into 6 smoke zones. The facility has a 100 KW Diesel Emergency Generator.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.	K 222		2/21/24

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

Electronically Signed | 02/21/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315274	A. BUILDING **01** B. WING _____	**02/09/2024**

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
K 222	Continued From page 1 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire	K 222		

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K 222	Continued From page 2 detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 02/08/2024 and 02/09/2024, it was determined that the facility failed to provide one (1) designated exit access (illuminated exit signs above doors) door with-in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 02/08/2024 (day one of survey) during the survey entrance at approximately 8:35 AM, a request was made to the U.S. FOIA (b) (6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1)building with three (3) enclosed (surrounded by the building) outside courtyards that Resident, Staff and Visitors could use. Starting at approximately 9:00 AM on 02/08/2024 and continued on 02/09/2024 in the presence of the facility U.S. FOIA (b) (6) [redacted]) and U.S. FO [redacted] an inspection tour of the building was conducted. During the building tour on 02/08/2024 at approximately 11:12 AM an inspection in the	K 222	Residents affected by deficient practice: " The designated exit access door leading out of the enclosed center courtyard had a Keyed doorknob and was in the locked position. 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: " The door was inspected and the doorknob was unlocked to allow the door to be free of all obstructions or impediments to be available for full instant use in the case of fire or other emergencies as of 2/8/2024 to open after 15 seconds in accordance with LSC 7.2.1.6.1. Measures or systemic changes to ensure that the deficiencies will not recur: " This will be monitored through audits of doors by the Maintenance Director/Designee. The audits will be weekly x4 weeks, then monthly x3 months. The results of the audits will be discussed quarterly by the Quality Assurance and Performance Improvement Committee.	

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K 222	Continued From page 3 "Front" outside enclosed center courtyard that Resident, Staff and Visitors could use was performed. The surveyor observed one of the designated (illuminated exit sign above the door) exit access doors leading out of the enclosed center courtyard had a "Keyed" door knob. The surveyor attempted to open the door. The door knob was in the locked position. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) confirmed the finding at the time of observation. The U.S. FOIA (b) (6) was informed of the deficiency during the Life Safety Code survey exit on 02/09/2024 at approximately 12:05 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 02/08/2024 and 02/09/2024 in the presence of facility management, it was determined that the facility failed to: 1) To provide one (1) illuminated exit sign to clearly identify the exit access path to	K 293	Residents affected by deficient practice: " Facility failed to provide illuminated exit sign to clearly identify the exit access path to reach an exit discharge door. Identify those individuals who could be	2/21/24

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K 293	Continued From page 4 reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or	K 293	affected by the deficient practice: " All residents had the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: " The exit sign was installed on the door that required it in the Memory Impaired (Wing 3) unit on 2/9/2024. Measures or systemic changes to ensure that the deficiencies will not recur: " All the exit signs will be monitored through audits by the Maintenance Director/Designee. The audits will be weekly x4 weeks, then monthly x3 months. The results of the audits will be discussed quarterly by the Quality Assurance and Performance Improvement Committee.	

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K 293	Continued From page 5 listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 02/08/2024 (day one of survey) during the survey entrance at approximately 8:35 AM, a request was made to the U.S. FOIA (b) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1)building with three (3) enclosed (surrounded by the building) outside courtyards that Resident, Staff and Visitors could use. Starting at approximately 9:00 AM on 02/08/2024 and continued on 02/09/2024 in the presence of the facility U.S. FOIA (b) (6)) and U.S. FO an inspection tour of the building was conducted. During the building tour on 02/08/2024 at approximately 10:35 AM an inspection in the Memory Impaired (Wing 3) units outside enclosed center courtyard was performed. The surveyor observed three (3) doors leading out of the enclosed center courtyard with only one door (Dining room door) that had an illuminated exit sign above the door to clearly identify the exit access route to reach an exit.There was no evidence of a second illuminated exit sign to identify the second exit access path to reach an exit. The U.S. FOIA (and U.S. FO confirmed the finding at the time of observation. The U.S. FOIA (b) (6) was informed of the deficiency	K 293		

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K 293	Continued From page 6 during the Life Safety Code survey exit on 02/09/2024 at approximately 12:05 PM. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire	K 363		2/21/24

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K 363	Continued From page 7 window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation on 02/08/2024 and 02/09/2024, in the presence of facility management it was determined that the facility failed to ensure that 1 of 26 corridor doors inspected and tested, were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. The evidence includes the following, On 02/08/2024 (day one of survey) during the survey entrance at approximately 8:35 AM, a request was made to the U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story (1)building with six (6) smoke zones. There are 95 Resident sleeping rooms and common areas. Starting at approximately 9:00 AM on 02/08/2024 and continued on 02/09/2024 in the presence of the facility U.S. FOIA (b) (6)) and U.S. FO an inspection tour of the building was conducted. During the two (2) day tour of the facility the	K 363	Residents affected by deficient practice: " Wing 2 Soiled Utility Room□s second door leading into the room had a 1/2 of an inch gap along the door□s top edge. Identify those individuals who could be affected by the deficient practice: " All residents had the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: " Wing 2 Soiled Utility Room□s second door leading into the room was repaired on 2/9/2024 to ensure that there is no gap along the door□s top edge. Measures or systemic changes to ensure that the deficiencies will not recur: " Five random doors in the facility will be inspected weekly x4 weeks, then monthly x3 months by the Maintenance Director/Designee to ensure that there is no gap present. " The results of the inspections will be discussed quarterly by the Quality Assurance and Performance	

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K 363	Continued From page 8 surveyor performed closure tests of the twenty-six (26) doors in the corridors with the following results, On 02/09/2024: 1) At approximately 9:47 AM, during a closure test of the Wing 2 Soiled Utility room's second door leading into the room, the surveyor observed, measured and recorded a 1/2 of an inch gap along the doors top edge. This would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) confirmed the finding at the time of observation. The U.S. FOIA (b) (6) was informed of the deficiency during the Life Safety Code survey exit on 02/09/2024 at approximately 12:05 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	Improvement Committee.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation on 02/08/2024 and 02/09/2024, in the presence of facility	K 911	Residents affected by deficient practice: " The Ground Fault Circuit /Interrupter	2/21/24

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K 911	Continued From page 9 management, it was determined that the facility failed to ensure that 1 of 12 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection as required. This deficient practice was evidenced by the following: Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 02/08/2024 (day one of survey) during the survey entrance at approximately 8:35 AM, a request was made to the U.S. FOIA (b) (6) [redacted] to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified	K 911	(GFCI) electrical outlet located adjacent to the hand washing sink in resident room #209 did not de-energize as required by code. 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: " The Ground Fault Circuit /Interrupter (GFCI) electrical outlet located adjacent to the hand washing sink in resident room #209 was repaired on 2/9/2024 to ensure that it de-energizes as required by code. Measures or systemic changes to ensure that the deficiencies will not recur: " Five random Ground Fault Circuit /Interrupter (GFCI) electrical outlets will be inspected weekly x4 weeks, then monthly x3 months by the Maintenance Director/Designee to ensure that there is no gap present. " The results of the inspections will be discussed quarterly by the Quality Assurance and Performance Improvement Committee.	

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K 911	Continued From page 10 the facility is a single-story (1)building with six (6) smoke zones. There are 95 Resident sleeping rooms and common areas. Starting at approximately 9:00 AM on 02/08/2024 and continued on 02/09/2024 in the presence of the facility U.S. FOIA (b) (6)) and U.S. FO an inspection tour of the building was conducted. During the two (2) day tour of the facility, the surveyor observed and tested twelve (12) electrical outlets in wet (with-in 6 feet of a sink) locations with one (1) electrical outlet that failed to de-energize when tested in the following location, On 02/09/2024: 1. At approximately 9:55 AM, inside the Resident room #209 bathroom, one Ground Fault Circuit Interrupter (GFCI) electrical outlet located adjacent to the hand washing sink when tested with a GFCI tester to de-energize, the GFCI electrical outlet did not de-energize as required by code. The U.S. FOIA (and U.S. FO confirmed the finding at the time of observation. The U.S. FOIA (b) (6) was informed of the deficiency during the Life Safety Code survey exit on 02/09/2024 at approximately 12:05 PM. Safety Hazard. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		

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
315274 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/10/2024 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 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	02/21/2024	LSC K0293	02/21/2024	LSC K0363	02/21/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0911	02/21/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
2/9/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO