STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315342	A. BUILDING _____ B. WING _____	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRICK LLC	415 JACK MARTIN BLVD BRICK, NJ 08724

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 07/6/2022 Census: 73 Sample: 18 + 2 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documents, it was determined that	F 812	1. Corrective action accomplished: a. Based on the RCA the team identified	7/7/22

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

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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.

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F 812	Continued From page 1 the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 6/21/2022 from 9:37 AM to 10:24 AM, the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen: 1. In the walk-in freezer an opened bag of chicken fingers on a middle shelf had no dates. The FSD stated, "They should be labeled with an open and use by date." 2. In the same walk-in freezer on a lower shelf, an opened package of frozen hash browns removed from its original container had no label or dates. On interview the FSD responded, "Same thing. Needs an opened and use by date." On an upper shelf a plastic bag contained frozen garlic bread and was removed from its original container. The garlic bread had no label or dates. 3. A Dietary Aide (DA) was observed working in the dish room area of the kitchen. The DA did not have a hair net on their head and all of their hair was exposed. When interviewed by the surveyor the FSD stated, "She should have a hair net on." 4. A previously opened container of Cole slaw in the sandwich bar refrigerator had a use by date of "6/20." The FSD threw the Cole slaw in the trash. On 7/5/2022 from 10:50 AM to 11:10 AM, the surveyor, accompanied by the FSD, observed the following in the kitchen:	F 812	the cause of the deficient practice to be failure to follow the policies of Food Labeling, Hair Restraints and Gloves, and Electronic Meat and Cheese Slicer. b. Education immediately provided by the Food Service Director to all dietary Team Members on proper food labeling and dating, hair restraint use and meat slicer sanitation and storage 2. Corrective action for residents taken: a. All residents have the potential to be affected b. an opened bag of frozen chicken fingers were discarded c. an open package of frozen hash browns were discarded d. a plastic bag of frozen garlic bread was discarded e. an opened container of cole slaw was discarded f. Dietary aide was immediately educated on hair net policy and donned a hair net g. Electronic Slicer was re-cleaned and sanitized and then covered when dried h. Provide visual aid on proper hair net use at the entryway of the kitchen i. Provide visual aid on proper slicer cleaning/sanitizing and storage procedure 3. Measures/changes put into place: a. Education provided by Food Service Director to all dietary team members on proper food labeling and dating, hair restraint use, and meat slicer sanitation and storage. Education will continue on a quarterly basis. b. Review and revise sanitation check list for shift usage	

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F 812	Continued From page 2 1. A cleaned and sanitized meat slicer on top of a metal counter in the cook's prep area of the kitchen was not in use, per interview with the FSD. The meat slicer was not covered while not in use and was exposed to dust and splash contamination. The FSD stated, "Our previous director said we don't have to do that, but I'll cover it from now on." The surveyor reviewed the facility policy titled Electronic Meat and Cheese Slicer, last revised on 05/2018. The following was revealed under the Procedure heading: Step 5: Action: After electronic slicer is cleaned and sanitized properly it must be covered with a clean cover or clean bag. The surveyor reviewed the facility policy titled Food Labeling, last revised 5/2018. The following was revealed under the Policy heading: "All food must be labeled properly upon delivery and after preparation. If food is not properly labeled it will be discarded." The following was revealed under the Labeling Upon Delivery Procedure: Step 1: Action: Once any food products are received they must be dated and labeled immediately. If applicable, the use by date must be labeled on the food item, in accordance with the Food Storage Chart (Please view Attachment: Food Storage Chart). Step 3: Action: If food is taken out of packaging that there is no label, they must be labeled what the product is. (Ground beef, chicken breast,	F 812	c. Hair net compliance audit tool developed and implemented d. Meat/cheese slicer compliance audit tool developed and implemented. 4. Corrective actions monitored: a. Sanitation checklist audit tool results reviewed for efficacy by Food Service Director on a monthly basis. b. Sanitation checklist audit tool to be completed monthly for six months and then quarterly thereafter and results reported at monthly QAPI meetings by the Food Service Director c. Hair net compliance audit tool results reviewed for efficacy by Food Service Director on a monthly basis d. Hair net compliance audit be done monthly for six months and then quarterly thereafter and results reported at monthly QAPI meetings by the Food Service Director e. Meat/Cheese slicer audit tool results reviewed for efficacy by Food Service Director on a monthly basis f. Meat/Cheese slicer audit to be completed monthly for six months and then quarterly thereafter and results reported at monthly QAPI meetings by the Food Service Director.	

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F 812	Continued From page 3	F 812		

parmesan cheese, etc.)

The following procedures were revealed under the Labeling After Food Preparation Delivery Procedure:

Step 1: Action: "After food preparation is complete and food will be stored for later cooking, reheating, or consumption, items must be labeled with description, preparation date, and expiration date. All dates in the following fashion: MM/DD/YY.

Step 2: Action: "The expiration date must not exceed 7 days, including the day of preparation and the day of service based on the FDA Food Code and Servsafe recommendations."

Step 5: Action: "Any items that are not labeled correctly must be discarded."

Step 6: Action: "Any items that have past the date of expiration must be discarded."

The surveyor reviewed the facility provided policy titled Hair Restraints and Gloves, last revised 5/2018. The following was revealed under the heading Policy:

"While in the kitchen all team members must wear proper head wear (hairnets, hats, beard restraints, etc.) to restrain hair and all team members must follow proper hand hygiene and glove use procedures.

The following was revealed under the heading Procedure:

Step 1: Action: Upon entering the kitchen all

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F 812	Continued From page 4 persons must put on a hair restraint. NJAC 18:39-17.2(g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, 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	F 880		9/30/22

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F 880	Continued From page 5 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the 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, and review of other facility documentation, it was determined that the facility failed to perform adequate handwashing to prevent the spread of infection as well as failed to follow their own Hand Hygiene policy. This deficient practice was identified for 1	F 880	1. Corrective actions accomplished: a. Based on RCA the team identified the cause of the deficient practice to be failure to follow the Facility policy on Hand Hygiene. When speaking with the Nurse, she stated, "she must have been counting	

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F 880	Continued From page 6 of 3 Licensed Practical Nurses (LPN) observed during medication administration. The deficient practice was evidenced by the following. On 06/24/22 at 8:19 AM, the surveyor observed the LPN begin medication administration for an unsampled resident. The LPN went to the resident room to obtain a blood pressure (BP) reading. After obtaining the BP reading, the LPN entered the resident's bathroom. At 8:20 AM, the surveyor observed the LPN turn on the faucet, wet her hands, apply soap, create friction outside the stream of water for 11 seconds, rinse her hands, dry her hands, and turn off the faucet. The LPN did not use alcohol-based hand sanitizer. The time was counted on the New Jersey Department Of Health computer clock. The LPN returned to the medication cart and gathered the resident's medications, including eye drops, and supplies. The LPN entered the resident's room and administered the oral medications. The LPN then performed hand hygiene. The LPN donned (put on) gloves and administered the eye drops. At 8:38 AM, the surveyor observed the LPN enter the resident's bathroom. The surveyor observed the LPN turn on the faucet, wet her hands, apply soap, create friction outside the stream of water for 10 seconds, rinse her hands, dry her hands, and turned off the faucet. The LPN did not use alcohol-based hand sanitizer. The time was counted on the NJDOH computer clock. On 06/24/22 at 8:41 AM, during an interview with the surveyor, the LPN stated hands should be	F 880	too fast, and I was nervous." The Nurse had an understanding of the policy. b. Education and Handwashing competency was immediately provided by the Staff Educator to the Nurse identified during Medication Pass 2. Corrective actions taken for residents: a. All residents have the potential to be affected 3. Measures/changes put into place: a. Re-education provided to all nurses on handwashing policy b. Return demonstration performed by the Nurse and met all practice steps for hand hygiene c. Staff Educator will continue Hand Hygiene Competencies bi-annually for all nursing staff. d. Handwashing instructions will be posted in all Facility bathrooms e. Include CDC handwashing video during building orientation for all new staff and on competency days to all nursing staff: 1. CDC COVID-19 Prevention Messages for Front Line Long Term Care Staff: Keep COVID-19 Out! (https://www.youtube.com/watch?v=7srwrF9MGdw).Frontline Staff 2. CDC COVID-19 Prevention Messages for Front Line Long Term Care Staff: Clean Hands (https://www.youtube.com/watch?v=xmYmUly7qiE)Frontline Staff f. Nurse identified as having deficient practice will complete the following training: 3. Module 1 Infection Prevention and	

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F 880	Continued From page 7 washed for 30 seconds of friction outside the water. The LPN stated, "I must be counting fast". The surveyor showed the LPN the clock used to time her handwashing. On 06/24/22 at 9:07 AM, during an interview with the surveyor, the Registered Nurse (RN) Unit Manager stated that handwashing friction should be done 20-30 seconds. On 06/24/22 at 9:16 AM, the Director of Nursing (DON) stated she believed the handwashing process in the facility was to wet hands, lather for 20 seconds. The DON stated she wanted to be sure so she would provide the facility policy. On 06/24/22 at 9:31 AM, the facility RN Educator stated the process for handwashing was to wet hands, apply soap, scrub for 20 seconds, rinse hands, dry hands, get another paper towel, and turn off the faucet. The RN Educator stated it was important to scrub for 20 seconds with friction to ensure germs were removed. She further stated that handwashing competencies were done on a yearly basis and as needed. The surveyor reviewed the facility provided, "Nurse Competency Day Station Checklist 2021", dated 08/21/21, for the LPN. The competency revealed that the LPN had met the requirements of donning and doffing all PPE (Personal Protective Equipment), handwashing demonstration, hand hygiene demonstration, and verbalizing understanding of isolation sign usage. A review of the facility provided, "Medication Pass Observation", dated 04/11/22, for the LPN, included but was not limited to an area for Med [medication] pass Technique: 10. Hand washing	F 880	Control Program (https://www.train.org/main/course/1081350)Topline Staff and Infection Preventionist 4. Nursing Home Infection Preventionist Training Course: Module 7 - Hand Hygiene (https://Train.org/main/course/1081806)All Staff including front line staff and infection preventionist 4. Corrective Actions to be monitored: a. Infection Preventionist and/or Staff Educator will perform 4 random spot checks monthly on nurses regarding Hand Hygiene compliance b. Monthly spot checks will be performed for a duration of 6 months and then quarterly based on compliance. c. All audits will be reported to the Director of Nursing monthly and will be reported at QAPI monthly.	

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F 880	Continued From page 8 (alcohol-based hand rub or soap and water per facility policy) a. before and after direct patient contact (e.g. BP, pulse), b. immediately before and after eye drops, c. between every resident even if patient contact is not made, d. immediately before and after use of gloves. The LPN was noted to have not had an opportunity to be observed with the eye drop administration. The LPN was noted to have met the hand washing requirements for the other situations. A review of the facility provided policy titled "Hand Washing/Hand Hygiene", last revised 03/22, included but was not limited to Purpose: to provide guidelines for hand washing and hand hygiene to prevent the spread of infection. Procedure: C. Hand Washing Method 7. Scrub the hands for at least 20 seconds. NJAC 8:39-19.4(a)	F 880		

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	656001	A. BUILDING: _____ B. WING _____	07/06/2022

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 observation, interview, and review of other facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This was evident for 3 of 14 day shifts and 1 of 14 evening shifts. 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	1. Corrective actions accomplished: a. Based on our RCA the team identified the case of the deficient practice to be failure to staff the facility to appropriate ratios based on NJ guidelines due to a global acute shortage of staff, specifically certified nursing assistants 2. Corrective actions taken for residents: a. All residents have the potential to be affected 3. The following measures/changes were put into place: a. implementation of referral bonus program and sign on bonus program to increase applicant pool and increase	7/7/22

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One 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 weeks of 06/05/22 to 06/11/22 and 06/12/22 to 06/18/22, revealed the facility was deficient in CNA staffing for residents on 3 of 14-day shifts and deficient for CNAs to total staff on 1 of 14 evening shifts as follows: On 06/05/22 had 8 CNAs for 82 residents on the day shift, required 10 CNAs. On 06/10/22 had 8 CNAs for 79 residents on the day shift, required 9 CNAs. On 06/12/22 had 8 CNAs for 79 residents on the day shift, required 9 CNAs. On 06/12/22 had 8 CNAs for 75 residents on the day shift, required 9 CNAs.	S 560	retention b. CNA classes to convert Provisional Nursing Aides to CNAs and thus increase staff c. Re-engineered hiring process to expedite on-boarding process. d. Market analysis of CNA rate of pay across the network e. Continued relationships with local CNA/Nursing schools to help build the applicant pool. f. Job fairs at local Community College g. Offering critical shift pay to current staff, including nurses working as CNAs to work additional hours while we look to fill vacancies through internal job postings, job fairs, and external job postings h. Contract with Agency Companies i. Adding extra nurses to work CNAs on 7-3 and 3-11 shifts when CNA staffing does not meet the requirement 4. How corrective actions monitored: a. Staffing Coordinator or designee will complete an audit of staffing and ratio requirements daily for one month, then weekly for 2 months and then monthly for 12 months. Audit will be give to the Director of Nursing. b. The Director of Nursing will report all findings to the Monthly QAPI meeting.	

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S 560	Continued From page 2 On 06/06/22 had 9 CNAs to 21 total staff on the evening shift, required 10 CNAs. On 06/24/22 at 09:30 AM, the surveyor interviewed a CNA who worked on the subacute unit. She stated usually she would have 8 residents during the day shift. The CNA also said when we are short of CNAs, the nurses will answer call lights and assist as needed. On 06/24/22 at 09:48 AM, during an interview with a Licensed Practical Nurse (LPN) who worked on the weekend, stated that if we are short of staff, she would assist CNAs as needed, and passed trays, assisted with toileting needs, answered call lights. She added that she also spoke with Managers regarding staffing issues. She added that she could not recall what they said they were going to do to resolve the staffing issues. 06/24/22 at 10:11 AM, during an interview with the Unit Manager regarding staffing revealed that on the weekends staffing can be a challenge. She said she worked as a supervisor and covered the facility once a month. She added, "when short of staff, I will assist as needed and informed management." We are very transparent and communicate concerns with staffing all the time. On 06/28/2022 at 11:55 AM, an interview with the Director Of Nursing revealed that the facility had been able to meet the minimum staffing requirements. She was not aware of any staffing issues. The DON said she was aware of minimum staffing requirements for nursing homes effective 02/01/21.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	656001	A. BUILDING: _____ B. WING _____	07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRICK LLC	415 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 3 On 06/28/2022 at 12:15 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) who stated the minimum staffing requirements for the state of New Jersey were one CNA per eight residents during the 7:00 AM - 3:00 PM shift, one CNA per ten residents on the 3:00 PM -11:00 PM shift, and one CNA for 14 residents on the 11:00 PM -7:00 AM shift. She also said she was not aware of any staffing issues. If the facility was in dire needs they would offer a bonus to staff who wanted to work an extra shift. In the presence of the DON, the LNHA informed the surveyor that the facility was currently experiencing no staffing shortages and that the facility used Agency contracted staff as needed to cover shifts. On 06/29/22 at 1:04 PM, the facility provided a policy titled, "(facility initials) Nursing Staffing Plan" with an initiated date of 04/13, which indicated the following: Under the Purpose section: To provide guidelines for appropriate nursing staffing levels to meet the needs of the residents/patients in the facility. Under the procedure section (10) revealed," Each facility will maintain the following minimum direct care staff-to-resident/patient ratios (see NJDOH Minimum Staffing Requirements 1/28/21.)...	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
656001 Y1	A. Building B. Wing Y2	10/5/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRICK LLC	415 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/07/2022	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	
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	
7/6/2022	☐ 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
315342 Y1	A. Building B. Wing Y2	10/5/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT BRICK LLC	415 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 F0812	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	07/07/2022	LSC	09/30/2022	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	
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?
7/6/2022	☐ YES ☐ NO