

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315228		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/02/2025	
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT COURT HOUSE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 144 MAGNOLIA DRIVE , CAPE MAY COURT HOUSE, New Jersey, 08210			
(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
F0000	INITIAL COMMENTS Complaint #: 2663295 Census: 97 Sample Size: 3 THE FACILITY IS IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.			F0000			01/09/2026

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 reverse for further 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.

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060507		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/02/2025	
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT COURT HOUSE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 144 MAGNOLIA DRIVE , CAPE MAY COURT HOUSE, New Jersey, 08210			
(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	
S0000	Initial Comments Complaint #: 2663295 Census: 97 Sample Size: 3 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 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.		S0000			12/22/2025	
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #: 2663295 Based on interviews and review of facility documents on 12/2/2025, it was determined that the facility failed to ensure staffing ratios were met for 1 of 14-day shifts reviewed. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,		S0560	The facility is actively recruiting for all Certified Nursing Assistant (CNA) shifts to comply with New Jersey State Mandated ratios. Schedules are created with ratios of 1:8 Day shift; 1:10 Evening shift and 1:14 night shift. A daily meeting is held to review the schedule and determine if any vacancies need to be filled. Weekends are reviewed on Fridays and monitored by the weekend supervisor. Open positions have been posted in surrounding communities to increase applicant pools. All residents have the potential to be affected by the deficient practice. The facility will continue to develop recruitment and retention strategies. Identify vacant positions and attempt to fill with current regular and per-diem staff. Review vacant shifts to create full-time and part-time positions where available. The Human Resources Director will meet weekly with corporate recruiters to advertise and track applicants. The Administrator/Designee will audit the effectiveness of strategies to include open positions filled, new hires, turnover and retention rates. Audits of daily staffing ratios will be conducted 1x daily for four		02/21/2026	

Office of Primary Care and Health Systems Management

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060507		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/02/2025	
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT COURT HOUSE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 144 MAGNOLIA DRIVE , CAPE MAY COURT HOUSE, New Jersey, 08210			
(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
S0560	Continued from page 1 codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing from 11/16/25-11/29/25, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: On 11/16/25 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs.			S0560	Continued from page 1 weeks then continue 1x weekly for 3 moths. Results of the audits will be reviewed at the monthly Quality Assurance and Performance Improvement Meeting through March 2026 to ensure compliance and re-assessed for further action.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315228		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/23/2026	
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT COURT HOUSE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 144 MAGNOLIA DRIVE , CAPE MAY COURT HOUSE, New Jersey, 08210			
(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
F0000	INITIAL COMMENTS A desk review of the facility's plan of corrects was conducted on 2/23/26in relation to 12/2/25complaint survey. The facility was found to be in compliance with 42 CFR part 483, Requirements for long term Care Facilities.			F0000			

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 reverse for further 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.

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060507		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/23/2026	
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT COURT HOUSE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 144 MAGNOLIA DRIVE , CAPE MAY COURT HOUSE, New Jersey, 08210			
(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
S0000	Initial Comments A desk review of the facility's plan of corrects was conducted on 2/23/26 in relation to 12/2/25 complaint survey. The facility was found to be in compliance with the state of New Jersey Administrative code, Chapter 8:39, standards for long term Care Facilities."			S0000			

Office of Primary Care and Health Systems Management

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