STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	**89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702**

(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 Complaint #: NJ00175822, NJ00176055, NJ00176481, NJ00177219 Survey Dates: 1/16/25 Census: 90 Sample Size: 5 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 804 SS=D	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: COMPLAINT#: NJ00176055 Based on observation, interview, and review of pertinent facility documentation on 1/16/25, it was determined that the facility failed to: a). serve hot foods at an acceptable temperature for the residents, and b). follow its "Test Tray Policy." This deficient practice was identified for a test	F 804	F804 - Nutritive Value/Appearance, Palatability, and Preferred Temperature of Food Correction Plan: 1. Dietary staff, including the [redacted] and dietary aides received in-person education by Regional Food Service Director on proper food handling, storage, and temperature	2/21/25

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

Electronically Signed — 01/31/2025

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 804	Continued From page 1 tray that was placed on the second cart that was delivered to the second floor unit during the lunch meal service. In addition to the test tray, the cart contained meals for 9 residents. This was evidenced by the following: Resident #2 was not at the facility at the time of the survey. On 1/16/25, at 10:32 A.M., during an interview with the [redacted] he stated, "If I received a complaint about food temperatures, I would do a test tray." The [redacted] stated that he could not recall when the last complaint was received, nor when he last completed a test tray. No documentation was provided to the surveyor. On 1/16/25, at 11:43 A.M., the surveyor observed the [redacted]) calibrate his thermometer at 32 degrees Fahrenheit (F). On 1/16/25, at 12:41 P.M., the dietary aide exited the kitchen with the meal cart, which included the test tray, accompanied by the surveyor and the [redacted]. At this time the [redacted] confirmed that he brought the calibrated thermometer with him. On 1/16/25, at 12:44 P.M., the dietary aide delivered the meal cart, which included the test tray, to the hallway of the second floor. On 1/16/25, at 12:46 P.M., the resident meal pass began. On 1/16/25, at 12:53 P.M., the last resident meal tray was served. On 1/16/25, at 12:54 P.M., in the presence of the	F 804	control procedures. This will include refresher training on the facility's "Food Temperatures and Holding Policy" and "Test Tray Policy." indicates that hot food should arrive to the resident above 135 degrees F. 2. All Residents have the potential to be affected by this deficient practice. 3. The FSD or designee will conduct weekly test trays for each meal period to ensure food temperatures meet the required 135°F for hot foods before being served to residents. 4. The FSD/Designee will report results of weekly test trays monthly to the QAPI Committee for three months. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315136	A. BUILDING _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	**89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702**

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F 804	Continued From page 2 surveyor, the [US FOIA (b)] took the following food temperatures: -Baked Ham: 117.7 degrees F -Roasted Potatoes: 123.9 degrees F -Broccoli: 121.6 degrees F At that time, the surveyor interviewed the [US FOIA (b)] regarding what the appropriate food temperature should be when the food was served. The [US FOIA (b)] stated that hot foods should be above 135 degrees when served. On 1/16/25, at 4:31 P.M., during an interview with the US FOIA (b)(6) the US FOIA (b)(6), and the [US FOIA (b)], the [US FOIA (b)] stated that the above noted foods did not meet the appropriate temperature. He further restated that test trays were only being conducted when a complaint was reported to him. The surveyor reviewed the facility's undated "Food Temperatures and Holding Policy," which indicated that, "Hot food should arrive to the resident above 135 degrees F." The surveyor reviewed the facility's undated "Test Tray Policy," which indicated that test trays were to be completed weekly at random mealtimes. The policy further revealed that the "Test Tray Forms" would be kept on file for one year. NJAC 8:39-17.4 (a)	F 804		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061326	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

(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 Complaint #: NJ00175822, NJ00176481, NJ00177219 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care 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 ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 4 day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	S560 Mandatory Access to Care 01/16/2025 1. All efforts to hire facility Certified Nursing Aide(s) will continue until there are adequate staff to serve all residents and actively recruit additional Certified Nursing Aides to ensure compliance. Until that time, the facility will utilize staffing agencies to fill any open spots in the schedule. Contracts with additional staffing agencies will be secured to	2/21/25

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

Electronically Signed | 01/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061326	A. BUILDING: _____ B. WING _____	C 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 07/21/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: - 07/21/24 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. 2. For the 2 weeks of staffing prior to survey from 12/29/2024 to 01/11/2025, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -12/29/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. -01/04/25 had 10 CNAs for 86 residents on the	S 560	supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listing, job fairs, shift differentials and referral bonuses /incentives are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator are being held. No resident was affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. Contracts with additional staffing agencies will be secured to supplement facility staff. Hiring and recruitment efforts including wage analysis and adjustments, pay for experience, online job listings, job fairs, shift differentials and referral bonuses are being utilized to become more competitive in the marketplace and surrounding area. In addition, daily and weekly meetings with the staffing coordinator. Contingency Planning: will be developed to address unexpected staffing shortages, including a pool of on-call Certified Nursing Aides. 4. The Administrator and DON will conduct bi-weekly staffing audits for three months and monthly thereafter to ensure continued compliance. Results of these reviews will be submitted to the (Quarterly Assurance Performance Improvement (QAPI) committee for review. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting/review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 day shift, required at least 11 CNAs. -01/05/25 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs.	S 560		

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
315136 Y1	A. Building B. Wing Y2	3/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

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 F0804	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(d)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/22/2025	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/16/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
061326 Y1	A. Building B. Wing Y2	3/3/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SHREWSBURY LLC	89 AVENUE AT THE COMMON SHREWSBURY, NJ 07702

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	02/22/2025	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/16/2025	☐ YES ☐ NO