STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

(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 #: NJ 173037, 174432, 180229, 180352, 184322, 185027, 185276 Survey Date: 4/14/25 Census: 136 Sample: 27 + 3 closed records. 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		6/19/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/19/2025

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F 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. 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 maintain the residents' living environment in a clean, comfortable, homelike manner. This deficient practice was identified on 3 of 3 nursing units reviewed for homelike environment (*NJ Ex Order 26. 4B1* [redacted]), and was evidenced by the following: On 4/24/25 at 9:43 AM, in the presence of the *U.S. FOIA (B)(6)* [redacted], the surveyor observed the following in the nourishment room on the *NJ Ex Order 26. 4B1* [redacted] unit: 1. The back splash and counter had *NJ Ex Order* [redacted] discoloration the length of the countertop joint.	F 584	The facility failed to maintain the residents' living environment in a clean, comfortable, homelike manner. This deficient practice was identified on 3 of 3 nursing units reviewed for homelike environment (*NJ Ex Order 26. 4B1* [redacted]). No residents were affected. All residents have the potential to be affected. The back splash and the countertop joint in the *NJ Ex Order 26. 4B1* [redacted] unit nourishment room were thoroughly cleaned and replaced to remove the identified *NJ Ex Order* [redacted] discoloration. The stains identified on the sink in the *NJ Ex Order 26. 4B1* [redacted] unit nourishment room were thoroughly cleaned and removed.	

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F 584	Continued From page 2 2. The sink had stains and NJ Ex Order 2 discoloration. 3. The counters and cabinets were peeling laminate and chipped paint. 4. The interior of the far-right lower cabinet had a spill that had dried and stained the cabinet with coffee grounds stuck to it. On 4/24/25 at 9:59 AM, in the presence of the U.S. FOIA (B)(6), the surveyor observed the following in the nourishment room on the NJ Ex Order 26. 4B1 unit: 1. The back splash and counter had NJ Ex Order 2 discoloration the length of the countertop joint. 2. The countertop right corner was broke, flaking of wood and had a hole in that was approximately 8 inches long. 3. The counters and cabinets were peeling laminate and chipped paint. 4. The inside of the cabinets and drawers had food debris and spilled items that were stuck on. On 4/24/25 at 10:23 AM, in the presence of the U.S. FOIA (B)(6), the surveyor observed the following in the nourishment room on the Applewood unit: 1. The back splash and counter had NJ Ex Order 2 discoloration the length of the countertop joint. 2. The counters and cabinets were peeling laminate and chipped paint. 3. The inside of the cabinets and drawers had large amounts of food debris and spilled items that were stuck on. On 4/24/25 at 10:25 AM, the surveyor interviewed with the contracted U.S. FOIA (B)(6), who stated that he had a weekly schedule in place to "deep" clean the nourishment rooms.	F 584	The chipped paint and peeling laminate on the counters and cabinets were thoroughly cleaned, removed, repaired, and replaced with new cabinet in the NJ Ex Order 26. 4B1 unit nourishment room. The dried spill and coffee grounds were thoroughly cleaned in the interior lower cabinet in the NJ Ex Order 26. 4B1 unit nourishment room. The back splash and countertop in the NJ Ex Order 26. 4B1 unit nourishment room were thoroughly cleaned and replaced to remove the identified NJ Ex Order 2 discoloration. The countertop right corner in the NJ Ex Order 26. 4B1 unit nourishment room was repaired, the flaking of wood was cleaned and removed, and area was repaired. The hole was repaired. The chipped paint and peeling laminate on the counters and cabinets were removed, repaired and replaced with new cabinet in the NJ Ex Order 26. 4B1 unit nourishment room. The food debris and spilled items were thoroughly cleaned and removed inside the cabinets and drawers in the NJ Ex Order 26. 4B1 unit nourishment room. The back splash and countertop in the NJ Ex Order 26. 4B1 unit nourishment room were thoroughly cleaned to remove the identified NJ Ex Order 2 discoloration. The peeling laminate and chipped paint in the counters and cabinets were thoroughly cleaned, removed, and repaired in the NJ Ex Order 26. 4B1 unit nourishment room. The food debris and spilled items were thoroughly cleaned and removed inside the cabinets and drawers in the	

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F 584	Continued From page 3 The surveyor inquired if he did audits on his staff, and the [redacted] replied, "no" I do not do audits, but I check the nourishment rooms "daily." The surveyor asked if he had seen them this week, and the [redacted] stated no. On 4/24/25 at 11:17 AM, the surveyor interviewed the U.S. FOIA (B)(6), who stated that he made rounds throughout the facility regularly and there were no plans in place to replace or fix the cabinets and counters at that time. The [redacted] stated if there was a maintenance issue or something was broken, all staff had access to the electronic maintenance system which provided the maintenance department with a work order if something needed to be fixed. On 4/24/25 at 11:25 AM, the surveyor interviewed the U.S. FOIA (B)(6) [redacted], who stated the only work order in for the facility was for furniture for the resident rooms. The [redacted] was unaware of the issue in the nourishment rooms. On 4/24/25 at 12:50 PM, the survey team met with the U.S. FOIA (B)(6), who both acknowledged the surveyor's concerns. They were unable to provide additional information. A review of the facility's "Maintenance Inspection" policy dated 9/1/24, included ...It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary and comfortable environment for residents, staff and the public.... all opportunities will be correct by maintenance personnel... NJAC 8:39 - 31.2	F 584	NJ Ex Order 26. 4B1 unit nourishment room. The cabinets were locked to avoid future debris and spilled items presence. The Housekeeping Services Staff were educated by the U.S. FOIA (B)(6) on 5/13/2025 on the following facility policy: Routine Cleaning and Disinfection to ensure compliance that residents' living environment is maintained in a clean, comfortable, homelike manner. The Maintenance Staff were educated by the Administrator on 5/13/2025 on the following facility policy: Maintenance Inspection to ensure that any identified and needed repairs are completed timely to ensure a safe, functional, sanitary and comfortable environment for the residents, staff, and public. The Maintenance Director/Designee will conduct compliance audits to ensure that areas of the building, including nourishment rooms, are in compliance with the regulation and facility policy. The Housekeeping Director/Designee will conduct compliance audits to ensure that areas of the building, including nourishment rooms, are in compliance with the regulation and facility policy. The Maintenance Director/Designee will conduct one weekly audit of two areas of the building for four weeks then two times a month for two months. The Housekeeping Director/Designee will conduct one weekly audit of two areas of the building for four weeks then two times a month for two months. Results of audits will be reviewed at the Quarterly Quality Assurance and	

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F 584	Continued From page 4	F 584	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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care for all residents, accurately. This deficient practice was identified for 3 of 27 residents reviewed for MDS (Resident #73, #99, and #101), and was evidenced by the following: 1. On 4/22/25 at 10:03 AM, the surveyor reviewed a list of NJ Ex Order 26. 4B1 provided by the facility. Resident #73 was identified as a NJ Ex Order 26. 4B. The surveyor reviewed the medical record for Resident #73. A review of the Admission Record face sheet (an admission summary) revealed that Resident #73 was admitted to the facility with medical diagnoses which included but were not limited to; NJ Ex Order 26. 4B1 [redacted]	F 641	The facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care for all residents, accurately. This deficient practice was identified for 3 of 27 residents reviewed for MDS (Resident #73, #99, and #101) Resident #73 MDS assessment was modified on NJ Exec Order 26.4b1 reflect the accurate information. Resident #99 MDS assessment was completed on NJ Exec Order 26.4b1 to reflect the accurate information. Resident #101 MDS assessment was modified on NJ Exec Order 26.4b1 to reflect the accurate information. All residents have the potential to be affected. On 5/12/2025, the U.S. FOIA (B)(6) [redacted] initiated education for MDS coordinators on "RAI" manual and coding assessments accurately as required.	6/19/25

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F 641	Continued From page 5 NJ Ex Order 26. 4B1 A review of the most recent comprehensive MDS dated NJ Exec Order 26., revealed the resident had a Brief Interview of Mental Status (BIMS) score of NJ Ex out of 15, which meant the resident had a NJ Ex Order 26. 4B1. A further review in Section NJ E Health Conditions, the question for NJ Exec Order 26.4 use was marked as "NJ Ex," which meant Resident #73 was assessed as a NJ Ex Order 26. 4B1. A review of the resident's Activities Assessment dated NJ Exec Order 26.4, included in the section titled participation, that the resident was a NJ Ex Order 26. 4B and joined peers at the designated breaks. A review of the resident's NJ Ex Order 26. 4B1 contracts, revealed the resident signed a quarterly NJ Ex Order 26. 4B1 contract in NJ Exec Order 26.4 NJ Ex Order. On 4/23/25 at 9:39 AM, the surveyor observed the resident outside during a NJ Ex Order 26. 4B1 session. On 4/23/25 at 10:45 AM, the surveyor interviewed the NJ Ex Order 26. 4B1, who stated the resident was a NJ Ex Order 26. 4B1 On 4/24/25 at 10:12 AM, the surveyor interviewed the U.S. FOIA (B)(6). The surveyor asked how she was informed if a resident was a NJ Ex Order 26. 4B. The NJ Ex Order 26. stated that there would be a NJ Ex Order 26. 4B1 assessment, she checked the medical record, and confirmed with the resident during an interview. The surveyor asked if the resident was a NJ Ex Order 26. 4B and she stated "NJ Ex Order 26.." 2. On 4/23/25 at 10:21 AM, the surveyor reviewed	F 641	The U.S. FOIA (B)(6) conducted an audit of current residents to ensure that MDS assessments were coded accurately as required. The Regional MDS Coordinator/Designee will conduct compliance audits of resident medical charts to ensure that the "Minimum Data Set (MDS)" was coded accurately. The Regional MDS Coordinator/Designee will conduct one weekly audit of three resident medical charts for four weeks, then two audits monthly for two 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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F 641	Continued From page 6 the MDS list for Resident #99. The list showed the last MDS that was completed for Resident #99 was a quarterly assessment completed on NJ Exec Order 26.4b [redacted]. A review of the Admission Record face sheet revealed that Resident #99 had medical diagnoses which included but were not limited to; *NJ Ex Order 26. 4B1* [redacted]. A review of the progress notes reflected a note written on NJ Exec Order 26.4b, which revealed the resident was on *NJ Ex Order 26. 4B1* [redacted]. On 4/24/25 at 10:30 AM, the surveyor interviewed the *U.S. FOIA (B)(6)* [redacted] regarding Resident #99. The surveyor asked how she was notified of a resident *NJ Ex Order 26. 4B1* [redacted]. The *U.S. FOIA (B)(6)* [redacted] stated she confirmed a resident's *NJ Ex Order 2* [redacted] by reading the progress notes and then completed a *NJ Ex Order 26. 4B1* MDS. The surveyor asked the *U.S. FOIA (B)(6)* [redacted] to look for the *NJ Ex Order 26. 4B1* MDS for Resident #99. The *U.S. FOIA (B)(6)* [redacted] confirmed there was not one, and stated "they missed it." 3. On 4/21/25 at 7:53 PM, during the initial tour of the facility, the surveyor observed Resident #101 was in bed with NJ Exec Order 26.4b1. The resident told the surveyor that they had a *NJ Ex Order 26. 4B1* [redacted]. The surveyor reviewed the medical record for Resident #101.	F 641		

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F 641	Continued From page 7 A review of the Admission Record face sheet revealed that Resident #101 was admitted to the facility with medical diagnoses that included but were not limited to; *NJ Ex Order 26. 4B1* [redacted]. A review of the physician's orders included an order for *NJ Ex Order 26. 4B1* to administer NJ Exec Order 26.4b1 at 6:00 PM, until the NJ Exec Order 26.4b1 has reached. A review of the most recent quarterly MDS dated NJ Exec Order 26., revealed that the resident had a BIMS score of out of 15, which meant the resident had *NJ Ex Order 26. 4B1*. A further review under section and NJ Exec Order 26.4b1 it was marked "" for tube (). On 4/24/25 at 10:40 AM, the surveyor interviewed the U.S. FOIA (B)(6) regarding Resident #101's NJ Ex Order 26. 4B tube. The surveyor asked if the MDS should have included the resident's, and the U.S. FOIA (B)(6) confirmed yes, and that the nurse who that completed the MDS had put a no. The U.S. FOIA (B)(6) stated that she would correct the error. NJAC 8:39-33.2 (d)	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		6/19/25

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F 677	Continued From page 8 by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to provide a resident with NJ Ex Or care during NJ Ex Order 26. 4B1 care. This deficient Practice was identified for 1 of 2 residents reviewed for NJ Ex Orde care (Resident #52), and was evidenced by the following: On 4/21/25 at 7:54 PM, the surveyor observed Resident #52 sitting in their wheelchair in their room. The resident's NJ Ex Order 26. 4B1 were NJ Exec O in NJ Exec Order with NJ Exec Order 26.4b1, and on their NJ Ex Order 26. 4B1, the NJ Ex Order 26. 4B1 had a NJ Ex Order 26. discoloration of the NJ Ex Orde On 4/22/25 at 11:24 AM, the surveyor reviewed the medical record for Resident #52. A review of the Admission Record face sheet (an admission summary) reflected the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26. 4B1 A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool, reflected the resident had a Brief Interview for Mental Status (BIMS) score of NJ out of 15, which indicated a NJ Ex Order 26. 4B1. The resident required NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1. A review of the individualized comprehensive care plan (ICCP) included a focused area for NJ Ex Order 26. 4B1. The intervention dated NJ Exec Order 26.4b1," indicated one staff member to assist and supervise that tasks have been completed.	F 677	The facility failed to provide a resident with NJ Ex Or care during NJ Ex Order 26. 4B1. This deficient Practice was identified for 1 of 2 residents reviewed for NJ Ex Orde care (Resident #52) Resident #52 was provided with proper NJ Ex Or care immediately upon notification on NJ Exec Order 26.4b1 All residents have the potential to be affected. On 5/12/2025, the U.S. FOIA (B)(6) initiated education for all Certified Nursing Assistants, Licensed Practical Nurses, and Registered Nurses regarding the requirement to provide residents with NJ Ex Or care in addition to education on the facilitys Activities of Daily Living policy. The U.S. FOIA (B)(6) conducted an audit of current residents to ensure that all residents have proper NJ Ex Or care as required. The Director of Nursing/Designee will conduct compliance audits to ensure that residents are receiving NJ Ex Or care as required. The Director of Nursing/Designee will conduct one weekly audit of three residents for four weeks, then two audits monthly for two 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	

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F 677	Continued From page 9 On 4/22/25 at 10:53 AM, the surveyor interviewed the resident if they preferred their [NJ Ex Order 26. 4B1] to be long in length, and the resident stated [NJ Ex]. The resident further stated that the last three digits on their [NJ Ex Order 26. 4B1] hurt to have them [NJ Exe] because they were so [NJ Orde]. On 4/23/25 at 1:16 PM, the surveyor interviewed the resident's assigned [U.S. FOIA (B)(6)], who stated it was the responsibility of the CNAs to provide [NJ Ex Or] care for the resident which included cleaning underneath the [NJ Ex Orde] and NJ Exec Order 26.4b1. The [U.S. FOIA (] stated that [NJ Ex Or] care was performed when needed, and she confirmed she did not perform [NJ Ex Or] care on the resident today. On 4/23/25 at 1:20 PM, the surveyor interviewed the [U.S. FOIA (B)(6)], who stated that the assigned [U.S. FOIA (B)] should do a visual assessment and look at their residents every shift. the [U.S. FOIA] stated if there were any issues noted, the nurse needed to make the physician aware and document it. The [U.S. FOIA] stated if the physician did not call back soon, then she placed another call out to them. The [U.S. FOIA] stated that the nurse also put any new findings on the 24-hour report (a facility document for supervisor) to let management know. On 4/23/25 at 1:34 PM, the surveyor interviewed the [U.S. FOIA (B)(6)], who stated that her expectations were for the staff to do a visual assessment every shift, and if there were any issues noted, they needed to make the physician aware and document. The [U.S. FOIA (B)(6)] stated the nurse should also update the care plan to reflect any new issues.	F 677	reporting.	

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F 677	Continued From page 10 On 4/24/25 at 10:34 AM, the surveyor interviewed the [redacted], who stated [redacted] care was performed by the CNAs, but all licensed nursing staff could perform care. The [redacted] further stated that the nursing staff should visualize the resident and their hands prior to performing hygiene care or distributing food trays. The [redacted] continued that the nursing staff should offer and assist the resident to wash their hands prior to eating. On 4/25/25 10:04 AM, in the presence of the survey team, the [redacted] acknowledged the resident's [redacted] were not cut until surveyor inquiry, and the ICCP did not include [redacted] care. No further information was provided. A review of the facility's "Activities of Daily Living" policy dated 9/1/24, included ... a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene...	F 677		
F 812 SS=F	NJAC 8:39-27.2 (g) 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	F 812		6/19/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 11 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a.) maintain kitchen equipment in a clean and sanitary manner and b.) maintain nourishment room refrigerators in a clean and sanitary manner on 3 of 3 units and was evidenced by the following: On 4/22/25 at 9:48 AM, in the presence of the U.S. FOIA (B)(6) the surveyor observed the following: 1. The microwave had multi-colored dried stuck on debris on the interior ceiling of the unit. The U.S. FOIA acknowledged it was not properly cleaned according to facility policy. 2. Two convection ovens were soiled with baked on NJ Ex Order 26. 4B1 on the glass doors and interior of the unit. The U.S. FOIA acknowledged and stated it was not cleaned according to facility policy. 3. Two steamer units had NJ Ex Order 26. 4B1 debris on the interior door and seal of door. The U.S. FOIA acknowledged and stated it was not cleaned according to facility policy.	F 812	The facility failed to a.) maintain kitchen equipment in a clean and sanitary manner and b.) maintain nourishment room refrigerators in a clean and sanitary manner on 3 of 3 units. No residents were identified. All residents have the potential to be affected. The identified microwave was thoroughly cleaned and all debris on the interior ceiling was removed. The identified two convection ovens were thoroughly cleaned and the baked NJ Ex Order 26. on the glass doors and the interior of the units was removed. The identified two steamer units were thoroughly cleaned and the NJ Ex Order 26. 4B1 debris on the interior door and seal of door was removed. The six-burner stove oven was thoroughly cleaned and the food sediment and debris on the interior and the interior door was removed. The catch tray was thoroughly	

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	315320	A. BUILDING _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 812	Continued From page 12 4. The six-burner stove top and oven were not clean. The U.S. FOIA stated the oven was used for "warming" only, and the surveyor observed food sediment and debris on the interior and the interior door. The surveyor also observed the catch tray that was lined with foil had burnt liquid and food debris covering the entire tray and foil. The U.S. FOIA acknowledged and stated it was not cleaned according to facility policy. 5. The double holder commercial plate warmer had food debris on the plate warmer section. The body of the unit had NJ Ex Order 26. 4B1 debris around the rim of the plate warmer. The U.S. FOIA acknowledged that the unit was not clean and that its purpose was too warm "clean plates" for distribution to the residents. He further stated it was not cleaned according to facility policy. 6. In the dining room, in the presence of the U.S. FOIA [redacted], it was observed to have a portable steam table that consisted of five individual steamer bays that were all filthy. Each bay had NJ Ex Order 26. 4B1 water, NJ Ex Order 26. 4B1 sediment stuck to the sides of water basin, food particles of vegetables and potatoes were noted in the water. The body of the table had food debris stuck on the glass shield and side walls. The front of the table had a white banquet skirt that was stained. The U.S. FOIA stated that it was supposed to be cleaned nightly or as needed in between resident dining. The U.S. FOIA acknowledged and stated it was not cleaned according to facility policy. On 4/24/25 at 9:43 AM, in the presence of the U.S. FOIA (B)(6) [redacted], the surveyor observed on all three of the nursing units in their nourishment rooms, the refrigerators all had	F 812	cleaned, and the burnt liquid and food debris and foil were removed. The identified double holder commercial plate warmer was thoroughly cleaned, and the food debris and the NJ Ex Order 26. 4B1 debris around the rim of the plate warmer were removed. The identified portable steam table was thoroughly cleaned and the NJ Ex Order 26. 4B1 white water, NJ Ex Order 26. 4B1 sediment stuck to the sides of water basin were removed. The food particles of vegetables and potatoes and water were removed. The debris on the class shield and side walls were removed and all areas were thoroughly cleaned. The stained white banquet skirt on the front of the table was removed and cleaned. The identified three refrigerators in the three nourishment rooms on all three nursing units were thoroughly cleaned and the sediment in the gaskets of the doors, frozen food spills in the freezer, and dirt on the outside handles were removed. On 5/13/2025, the U.S. FOIA (B)(6) [redacted] initiated education for dietary staff on the facility policies titled Cleaning of kitchen Equipment. Cleaning and Maintaining the Steam Table. On 5/13/2025, the housekeeping services staff were educated by the Administrator on the requirement to clean pantry rooms and equipment, including refrigerators, and maintain in a sanitized way to prevent food borne illness and contamination. The Food Service Director/Designee will conduct compliance audits to ensure that all kitchen equipment is cleaned as	

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	315320	A. BUILDING _____ B. WING _____	C 04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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F 812	Continued From page 13 sediment in the gaskets of the doors, frozen food spills in the freezer, and dirt on the outside handles. The [redacted] acknowledged and stated it was not cleaned according to facility policy, and that she would contact housekeeping. On 4/24/25 at 10:52 AM the surveyor interviewed the [redacted], who acknowledged that the equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination for safety of the residents. On 4/24/25 at 11:17 AM, the surveyor interviewed the [redacted], who acknowledged that the pantry equipment should have been cleaned and maintained in a sanitized way to prevent food borne illness and contamination. On 4/24/25 at 12:45 PM, the survey team met with the [redacted], who both acknowledged the surveyor's concerns. No additional information was provided. A review of the facility's undated "Cleaning of kitchen Equipment Policy" policy included Ovens ...ensure all debris and grease are removed from interior surfaces ... Drip trays; change foil weekly or more frequently if soiled ... Steamer; weekly, remove door plates and clean gaskets thoroughly to prevent buildup and maintain a proper seal ...Microwave: at the end of each day, clean interior walls and surfaces ... A review of the facility's undated "Cleaning and Maintaining the steam table policy" included all dietary staff are responsible for proper use, cleaning and maintenance of the steam table...	F 812	required and according to policy. The Housekeeping Director/Designee will conduct compliance audits to ensure that all equipment, including refrigerators, in the three nourishment rooms, are cleaned thoroughly to be in compliance as required. The Food Service Director/Designee will conduct one weekly audit of kitchen equipment for four weeks then two times a month for two months. The Housekeeping Director/Designee will conduct one weekly audit of nourishment rooms for four weeks then two times a month for two 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
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COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE TOMS RIVER, NJ 08757**

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F 812	Continued From page 14 NJAC 8:39-17.2(g)	F 812		

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
315320 Y1	A. Building B. Wing Y2	6/26/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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 F0584	Correction	ID Prefix F0641	Correction	ID Prefix F0677	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.24(a)(2)	Completed
LSC	06/19/2025	LSC	06/19/2025	LSC	06/19/2025
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/19/2025	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	

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?
4/25/2025	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING _____	**04/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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E 000	Initial Comments This facility is 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		
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 4/30/25 and 5/1/25 and the facility was found to be in non-compliance 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 Occupancy The nursing home building construction was stated to be 1990's with no current major renovations or noted additions. It is a one story building Type II (111) construction and is fully sprinklered. The outside 175 KW diesel generator powers approximately 40% of the building. The building utilizes an electric fire pump to support the fire sprinkler system. The floor plan indicates 14- smoke zones throughout the facility. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, electric fire pump, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life	K 000		

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

Electronically Signed | 05/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 The facility has 180 certified beds. At the time of the survey the census was 136.	K 000		
K 281 SS=F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/25/25 in the presence of the U.S. FOIA (B)(6) , it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3* (2) . This deficient practice was observed in 2 of 4 areas, had the potential to affect all residents and was evidenced by the following: 1). An observation at 11:18 AM revealed in the main occupied dining room, that 2-wall light switches shutoff all ceiling and wall light fixtures. 2). An observation at 12:00 PM revealed in the NJ Ex Order 26. 4B1 exit/egress corridor, that 2-light switches shutoff all 21-ceiling light fixtures. In an interview, the U.S. FOIA (B)(6) both confirmed the findings at the time of observations.	K 281	The facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8.1.3. No residents were affected by this deficient practice. All residents have the potential to be affected. On 5/9/2025, the U.S. FOIA (B)(6) was educated by the U.S. FOIA (B)(6) on the requirement that emergency illumination must operate automatically along the means of egress as required. The wall switches in the main occupied dining room were covered with a switch guard on 4/25/2025 to ensure that the lights are continuously in operation as required. The 2-lights switches in the NJ Ex Order 26. 4B1 exit/egress corridor were covered by a switch guard on 4/25/2024 to ensure that	6/19/25

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K 281	Continued From page 2 The U.S. FOIA (B)(6) was informed of the deficient practice at the Life Safety Code survey exit conference on 4/25/25 at 2:00 PM. NJAC 8:39-31.2(e)	K 281	the ceiling light fixes remain continuously in operation as required. All areas of the building were inspected by the U.S. FOIA (B)(6) to ensure that there is maintained emergency illumination of the means of egress as required. The Maintenance Director/Designee will conduct compliance audits to ensure that all areas of the building are inspected to maintain emergency illumination of the means of egress as required. The Maintenance Director/Designee will conduct one weekly audit of two areas of the building for four weeks then two times a month for two 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.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		6/19/25

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K 321	Continued From page 3 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 4/25/25 in the presence of the *U.S. FOIA (B)(6)* [redacted], it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice had the potential to affect all residents and staff in that identified area, for 1 of 5 doors observed and was evidenced by the following: An observation at 10:38 AM revealed that 1 of 2 doors from the laundry room to the exit/egress corridor was provided with a metal fire rating label, but the label was painted on the (left)dirty-side entrance. The clean-side entrance	K 321	The facility failed to ensure that fire-rated doors to hazardous areas were self-closing, labeled and were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Sections 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. No residents were affected by this deficient practice. All residents have the potential to be affected. On 5/9/2025, the *U.S. FOIA (B)(6)* was educated by the *U.S. FOIA (B)(6)* on the requirement that fire-rated doors to hazardous areas must be self-closing, labeled and separated by smoke resisting	

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K 321	Continued From page 4 was provided with a new door and unpainted label. In an interview at the time, the U.S. FOIA (B)(6) both confirmed the observations. The U.S. FOIA (B)(6) was informed of the deficient practice at the Life Safety Code exit conference on 4/25/25 at 2:00 PM. NJAC 8:39-31.2 (e)	K 321	partitions as required. The identified door from the laundry room to the exit/egress corridor was checked, the label was cleaned and paint was removed to clearly show the label of the fire rating on the left side on 5/16/2025. All fire-rated doors to hazardous areas were inspected by the U.S. FOIA (B)(6) [redacted] to ensure that they meet the requirement. The Maintenance Director/Designee will conduct compliance audits to ensure that fire-rated doors to hazardous areas are self-closing, labeled and separated by smoke resisting partitions as required. The Maintenance Director/Designee will conduct one weekly audit of two areas of the building for four weeks then two times a month for two 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.	
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited	K 324		6/19/25

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COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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K 324	Continued From page 5 cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 4/25/25 in the presence of the *U.S. FOIA (B)(6)* it was determined the facility failed to perform monthly Owners Inspections of the range-hood wet chemical fire suppression system in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:51 PM of the kitchen range-hood wet chemical fire suppression system inspection tag revealed the semi-annual inspection was performed in January 2025 and there were no monthly inspections listed on the	K 324	The facility failed to ensure to perform monthly Owners Inspections of the range-hood wet chemical fire suppression system in accordance with NFPA 17 A: 2009 Edition, Section 7.2, 7.2.1 to 7.2.6 and NFPA 96: 2011 Edition, Sections 11.2.1 and 11.2.3. No residents were affected by this deficient practice. All residents have the potential to be affected. On 5/9/2025, the *U.S. FOIA (B)(6)* was educated by the *U.S. FOIA (B)(6)* on the requirement to perform monthly Owners Inspections of the range-hood wet chemical fire suppression system as required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. BUILDING **01** B. WING _____	**04/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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K 324	Continued From page 6 back of the tag. The facility did not have documentation indicating the monthly Owners Inspection had been performed during the last 12 months. In an interview at the time, the U.S. FOIA (B)(6) both confirmed the observation and the U.S. FOI stated they did not perform an Owners Inspection. The U.S. FOIA (B)(6) was informed of the deficient practice at the Life Safety Code exit conference on 4/25/25 at 2:00 PM. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 17 A, 96	K 324	The identified range-hood wet chemical fire suppression system was checked, and the monthly inspection was completed on 5/9/2025. The Maintenance Director/Designee will conduct compliance audits to ensure that monthly Owners Inspections of the range-hood wet chemical fire suppression system are completed as required. The Maintenance Director/Designee will conduct one monthly audit for three 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.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/25/25 in the presence of the U.S. FOIA (B)(6) , it was determined that the facility failed to ensure that areas open to the corridor were provided with smoke detection in accordance with NFPA 101, 2012 Edition, Section 19.3.6.1 and 19.3.4.5.2. This deficient practice	K 347	The facility failed to ensure that areas open to the corridor were provided with smoke detection in accordance with NFPA 101, 2012 Edition, Section 19.3.6.1 and 19.3.4.5.2. No residents were affected by this deficient practice.	6/19/25

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	315320	A. BUILDING **01** B. WING _____	**04/25/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	**4 PLAZA DRIVE** **TOMS RIVER, NJ 08757**

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K 347	Continued From page 7 had the potential to affect 35 residents and was observed in 1 of 4 occupied open areas as evidenced by the following: An observation at 10:50 AM with the U.S. FOIA (B)(6) revealed in the occupied NJ Ex Order 26. 4B1 day room, that the door had an electro-magnetic closing device that closed the door in the event of an fire alarm activation. The room had 3 (three)approximately 4-foot by 4-foot windows that were removed and open to the exit/egress corridor by the nurse station. This area was not provided with smoke detection. In an interview at the time, the U.S. FOIA (B)(6) both both confirmed the finding. The U.S. FOIA (B)(6) was informed of the finding at the Life Safety Code exit conference on 4/25/25. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 347	All residents have the potential to be affected. On 5/9/2025, the U.S. FOIA (B)(6) was educated by the U.S. FOIA (B)(6) on the requirement to ensure that areas open to the corridor have smoke detection as required. The identified day room was provided with smoke detection as required on 5/19/2025. All open areas to the corridor were inspected by the U.S. FOIA (B)(6) to ensure that they meet the requirement. The Maintenance Director/Designee will conduct compliance audits to ensure that all open areas to the corridor in the building have smoke detection as required. The Maintenance Director/Designee will conduct one weekly audit of two areas of the building for four weeks then two times a month for two 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.	
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an	K 351		6/19/25

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	315320	A. BUILDING **01** B. WING _____	**04/25/2025**

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K 351	Continued From page 8 approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/25/25 in the presence of the U.S. FOIA (B)(6) , it was determined that the facility failed to ensure that the facility was protected throughout by an approved automatic sprinkler system in accordance with NFPA 101:2012 Edition, Sections 19.3.5.1, 9.7 and NFPA 13, Standard for the installation of Sprinkler Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:10 PM revealed in the NJ Ex Order 26. 4B1 room, that 2-closets did not have any sprinkler protection. The closets were next to each other and were approximately 8-foot by 30-inches and 4-foot by 30-inches. The closets were currently storing combustible items. In an interview at the time, the U.S. FOIA (B)(6) confirmed the observations.	K 351	The facility failed to ensure that the facility was protected throughout by an approved automatic sprinkler system in accordance with NFPA 101:2012 Edition, Sections 19.3.5.1, 9.7 and NFPA 13, Standard for the installation of Sprinkler Systems. No residents were affected by this deficient practice. All residents have the potential to be affected. On 5/9/2025, the U.S. FOIA (B)(6) was educated by the U.S. FOIA (B)(6) on the requirement to ensure that the facility is protected throughout by an approved automatic sprinkler system as required. The automatic fire sprinklers will be installed in the 2 -closets identified in the NJ Ex Order 26. 4B1 room by 6/16/2025.	

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K 351	Continued From page 9 The U.S. FOIA (B)(6) was informed of the deficient practices at the Life Safety Code exit conference on 4/25/25 at 2:00 PM. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 13	K 351	All areas were inspected by the U.S. FOIA (B)(6) on 5/9/2025 to ensure that automatic fire sprinkler protection existed as required. The Maintenance Director/Designee will conduct compliance audits to ensure that the facility is protected throughout by an approved automatic sprinkler system as required. The Maintenance Director/Designee will conduct one weekly audit of two areas of the building for four weeks then two times a month for two 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.	
K 741 SS=F	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language	K 741		6/19/25

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K 741	Continued From page 10 that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observations and interviews on 4/25/25 in the presence of the U.S. FOIA (B)(6) , it was determined that the facility failed to ensure that metal containers with self-closing cover devices were readily available to all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4, This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:30 AM revealed a metal container with a self-closing cover device into which ashtrays can be emptied was not provided or readily available to the smoking area courtyard. In an interview at the time, the U.S. FOIA (B)(6) both confirmed the observation. The U.S. FOIA (B)(6) was informed of the deficient practice at the Life Safety Code exit conference on 4/25/25 at 2:00 PM.	K 741	The facility failed to ensure that metal containers with self-closing cover devices were readily available to all areas where smoking is permitted in accordance with NFPA 101:2012 Edition, Section 19.7.4, No residents were affected by this deficient practice. All residents have the potential to be affected. On 5/9/2025, the U.S. FOIA (B)(6) was educated by the U.S. FOIA (B)(6) on the requirement to ensure that metal containers with self-closing cover devices were readily available to all areas where smoking is permitted as required. The smoking area was inspected by the U.S. FOIA (B)(6) and a self-closing cover device was provided on 5/15/2025 in the smoking area to be readily available to meet the requirement.	

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K 741	Continued From page 11 N.J.A.C 8:39-31.2(e)	K 741	The Maintenance Director/Designee will conduct compliance audits to ensure that self-closing cover devices are readily available to all areas where smoking is permitted as required. The Maintenance Director/Designee will conduct one weekly audit for four weeks then two times a month for two 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.	

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
315320 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/26/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HOLIDAY CITY	4 PLAZA DRIVE TOMS RIVER, NJ 08757

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 K0281	06/19/2025	LSC K0321	06/19/2025	LSC K0324	06/19/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0347	06/19/2025	LSC K0351	06/19/2025	LSC K0741	06/19/2025
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?
4/25/2025	☐ YES ☐ NO