STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755

(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 Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). Complaint #: NJ186440, NJ188127, NJ172698, and NJ176720. Survey Dates: 07/28/25 through 07/31/25 Survey Census: 159 Sample Size: 32 Supplemental Residents: 20 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 Recertification and Complaint visit.	F0000		08/26/2025
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F0842	F0842 Residents affected by deficient practice: The facility failed to have a complete and accurate medical record for three out of 32 sampled residents. The Notice of Emergency Transfer did not include “the specific reason and basis for transfer or discharge” for Resident (R)164 and 126. Patient R191 - was admitted to the facility with diagnosis that included NJ Ex Order 26.4(b)(1) [redacted], however, no documentation of the NJ Ex Order 26.4(b)(1) was on admission note. Upon second NJ Ex Order 26.4(b)(, NJ Ex Order 26.4(b)(1) noted NJ Ex Order 26.4(b) and NJ Ex Order 26 noted NJ Ex Order 26.4(b)(1) . Identify those individuals who could be affected by the	09/12/2025

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = D	Continued from page 1 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F0842	Continued from page 1 deficient practice: All residents have the potential to be affected. Resident (R) 164, 191, and 126 were discharged from facility. What corrective action will be accomplished for those residents affected by the deficient practice: On 8/1/25, Social workers were educated by the Administrator on the Transfer and Discharge Policy including correct verbiage for Discharge Transfer Form. Education initiated on 8/1/25. To all licensed nurses by the Director of Nursing on the Skin Assessment Policy including proper admission notes/assessments. On 8/14/25 Clinical Educator from NJ Ex Order 26.4(b)(1) did an in-person education on Wound Documentation and Assessments Measures or systemic changes to ensure that the deficiencies will not recur: The Administrator/ Designee will conduct compliance audits on all discharge/transfer forms to ensure the specific reason and basis for transfer or discharge has been documented. This audit will be done weekly for 4 weeks, then twice monthly for 2 months. On 8/1/25 Director of Nursing/ADON conducted audit of all new admissions/readmissions from the last 30 days that are currently in the facility, to ensure that admission wound documentation was done completely and accurately. Director of Nursing/Designee will audit/perform admission skin assessments on 4 patients weekly for 4 weeks, then two times monthly x2 months, ensuring completeness and accuracy of nursing documentation.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0842 SS = D	Continued from page 2 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and document review, the facility failed to have a complete and accurate medical record for three out of 32 (Resident (R) 126, R164, and R191) sampled residents. This failure had the potential to adversely affect the care of these residents with inaccurate information in the medical record. Findings include: 1. Review of R126's undated "Face Sheet," located under the "Profile" tab in the electronic medical record (EMR), indicated R126 was admitted to the facility on NJ Ex Order 26.4(with diagnoses that included NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) and NJ Ex Order 2 Review of R126's admission "Minimum Data Set (MDS)," located under the "MDS" tab in the EMR and with an Assessment Reference Date (ARD) of NJ Ex Order 26.4(, indicated R126 had a "Brief Interview of Mental Status (BIMS)" score of NJ Ex(out of 15, which indicated R126 was NJ Ex Order 26.4(b)(1) . Review of R126's "Nursing Progress Notes," located under the "Progress Note" tab in the EMR, indicated on NJ Ex Order 26.4(at 2:49 PM, ". . . During medication pass, patient noted to be NJ Ex Order 26.4(b)(1) . Responds to NJ Ex Order 26.4(b)(1). Call placed to [name of medical doctor (MD)], informed of current status. Orders received . . . 12 PM [sic]patient seen by U.S. FOIA (b) (6)], patient noted with NJ Ex Order 26.4(b)(1) . Call placed to [name of medical doctor (MD)], order received to send patient to [name of hospital] for eval [evaluation] . . ."	F0842	Continued from page 2 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. Date of Completion: 9/12/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755

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F0842 SS = D	Continued from page 3 Review of R126's "Notice of Emergency Transfer," provided by the facility and dated NJ Ex Order 26.4, indicated the reason for transfer was 'NJ Ex Order 26.4(b)(1)." 2. Review of R164's undated "Face Sheet," located under the "Profile" tab in the EMR, indicated R164 was admitted to the facility on NJ Ex Order 26.4 with diagnoses that included NJ Ex Order 26.4(b)(1) . Review of R164's "MDS" could not be completed as the admission MDS had not been completed at the time of transfer to the hospital on NJ Ex Order 26.4(b) Review of R164's "Nursing Progress Notes," located under the "Progress Note" tab in the EMR, indicated on NJ Ex Order 26.4 at 12:40 PM, ". . . Writer met with patient and spoke to NJ Ex Order 26.4(via [by] video call. [sic] regarding NJ Ex O management and patient's constant NJ Ex Order 26.4(b)(1) despite pharmacological and non-pharmacological interventions. Both expressed NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) as NJ Ex O medications are not helping her NJ Ex Order 26.4(b)(1). [Name of MD] notified with orders to send patient out to [name of hospital] . . ." Review of R164's "New Jersey Universal Transfer Form," dated NJ Ex Order 26.4 and provided by the facility, indicated the reason for transfer was 'NJ Ex Order 26.4(b)(1) ." Review of R164's "Notice of Emergency Transfer," provided by the facility and dated NJ Ex Order 26.4(b, indicated the reason for transfer was for "Evaluation." During an interview on 07/31/25 at 5:30 PM, the U.S. FOIA (b) stated, "I read in the notes where the patient was admitted to the hospital and put the reason why the patient was admitted for the reason for transfer." During an interview on 07/31/25 at 5:30 PM, the U.S. FOIA (b) (6) stated, "We are doing this paperwork in retrospect, and we thought the reason for admission was the reason the resident was being transferred to the hospital."	F0842		

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F0842 SS = D	Continued from page 4 Review of the facility's policy titled, "Transfer and Discharge (including AMA [Against Medical Advice])," dated with a revision date of 03/10/25, indicated, ". . . The facility's transfer/discharge notice will be provided to the resident and resident's representative. in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. The specific reason and basis for transfer or discharge . . ." 3.Review of R191's undated "Face Sheet," located under the "Profile" tab in the EMR, indicated R191 was admitted to the facility on [NJ Ex Order 26.4] with diagnoses that included NJ Ex Order 26.4(b)(1) [redacted] Review of R191's admission "MDS," located under the "MDS" tab of the EMR and with an ARD of [NJ Ex Order 26.4(b)], indicated R191 had a "BIMS" score of [NJ Ex] out of 15, which indicated R191 was NJ Ex Order 26.4(b)(1) . There was no documentation of the NJ Ex Order 26.4(b)(1) [redacted] on this form. Review of R191's "Nursing Progress Notes," located under the "Progress Note" tab in the EMR and dated [NJ Ex Order 26.4] at 2:16 PM, indicated, ". . . 2nd [sic] [NJ Ex Order 26.4(b)(1)] [redacted] NJ Exec Order 26.4b1 [redacted] [sic] . . ." During an interview on 07/31/25 at 2:29 PM, Licensed Practical Nurse (LPN) 2 stated, "I should have documented the appearance of what I was seeing regarding the [NJ Ex Order 26.4(b)(1)]." During an interview on 07/31/25 at 4:30 PM, the U.S. FOIA (b) (6) [redacted] stated, "The nurse should document the description of the [NJ Ex Order] if the resident has one." Review of the facility's policy titled, "Skin Assessment," dated 09/01/24, indicated ". . . Documentation of skin assessment . . . Describe wound . . ." NJAC 8:39-4.1(a)	F0842		

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F0842 SS = D	Continued from page 5 NJAC 8:39-35.2	F0842		
F0881 SS = D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, policy review, and review of [NJ Exec Order] criteria, the facility failed to have an [NJ Ex Order 26.4(] Stewardship Program that followed current standards of practice for prescribing [NJ Ex Order 26.4(b)(1)] for one of four residents (Resident (R) 99) reviewed for [NJ Ex Order 26.4(] stewardship out of total sample of 32. This failure had the potential to cause residents to be prescribed [NJ Ex Order 26.4(b)] that were potentially unnecessary. Findings include: Review of the facility's policy titled, "Infection Surveillance," dated 09/01/2,4 indicated, "A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections . . . The CDC's [Centers for Disease Control] National Healthcare Safety Network (NHSN) Long Term Care Criteria, updated McGeer criteria or other nationally-recognized [sic] surveillance criteria will be used to define infections . . ." Review of R99's undated "Face Sheet," located under the "Profile" tab in the electronic medical record (EMR), indicated R30 was admitted to the facility on [NJ Ex Order 26.4(] with the most recent diagnosis being [NJ Ex Order 26.4(b)(1)]	F0881	F0881- Residents affected by deficient practice: The facility failed to have an Antibiotic Stewardship Program that followed current standards of practice for prescribing [NJ Ex Order 26.4(b)(1)] for one (R99) of four residents reviewed for [NJ Ex Order 26.4(] Stewardship out of total sample of 32 residents. Identify those individuals who could be affected by the deficient practice: All residents who need antibiotics have the potential to be affected. R99 was discharged from the facility What corrective action will be accomplished for those residents affected by the deficient practice: On 8/1/25, the Regional Clinical Director educated the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] on the Infection Surveillance policy. On 8/1/25 the Director of Nursing initiated education to all licensed nurses on the Infection Surveillance Policy including Antibiotic Stewardship documentation and surveillance. The Director of Nursing audited all current residents on antibiotics to ensure criteria were documented and antibiotic surveillance discussed with physician. Measures or systemic changes to ensure that the deficiencies will not recur: The Director of Nursing/Designee will conduct compliance audits of residents receiving antibiotic therapy to ensure criteria were documented and	09/12/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755

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F0881 SS = D	Continued from page 6 Review of R99's "Nursing Progress Notes," located under the "Progress Note" tab in the EMR and dated [redacted] at 6:59 AM, indicated, ". . . Patient [redacted] w/chair [wheelchair] [redacted] X [times] 2 [sic] nights. MD [medical doctor] Dr. [doctor] notified via [by] text; awaiting response [sic]." Review of R99's "Nursing Progress Notes," located under the "Progress Note" tab in the EMR and dated [redacted] at 9:46 AM, indicated, ". . . labs referred, new order to start [redacted]] 1 [sic] tab po [by mouth] x7 [sic] days BID [twice a day], POA [Power of Attorney] made aware, order carried out . . ." Review of R99's '[redacted] lab report, provided by the facility and with a collection date of [redacted] and a reported date of [redacted] revealed the [redacted] was performed. Review of R99's '[redacted]" lab report, provided by the facility and with a collection date of [redacted] and a reported date of [redacted], revealed results of the [redacted] being [redacted] Review of R99's untitled infection surveillance form, provided by the facility and dated [redacted], indicated the form was not filled out completely and the area marked was '[redacted] criteria NOT met." During an interview on 07/31/25 at 5:30 PM, the [redacted]) and the [redacted]) confirmed the rationale of obtaining [redacted] and [redacted] should not have been patient [redacted] wheelchair [redacted] even though they stated this was [redacted] for the patient to do. NJAC 8:39-19.4(d)	F0881	Continued from page 6 antibiotics surveillance discussed with physician. The audits will be completed for two residents weekly x4 weeks then two residents monthly x2 months. Results of audits will be reviewed at Quarterly Quality Assurance and Performance Improvement Committee Meeting over the duration of the audit process. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting. Date of Completion 9/12/24	

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **061531**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **07/31/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	**1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755**

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S0000	Initial Comments The facility is in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities.	S0000		08/26/2025

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	**1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755**

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/15/2025 in relation to the 7/31/2025 Recertification 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/31/25 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 Occupancies. Complete Care at Green Acres is a three-story building built in 1965. It is composed of Type II protected construction. The facility is divided into 12 - smoke zones. The generator powers approximately 70% of the building per the Maintenance Director. The current occupied beds were 159 of 167.	K0000		09/30/2025
K0163 SS = F	Interior Nonbearing Wall Construction CFR(s): NFPA 101 Interior Nonbearing Wall Construction Interior nonbearing walls in Type I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls required to have a minimum 2 hour fire resistance rating are permitted to be fire-retardant-treated wood enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. 19.1.6.4, 19.1.6.5 This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure penetrations in the smoke barriers were properly sealed with an approved fire stop system in accordance with NFPA 101 Life Safety Code (2012 Edition) section 300.11 (A). This deficient practice had the potential to affect 93	K0163	K0163 Based on observations and interviews, it was determined that the facility failed to ensure penetrations in the smoke barriers were properly sealed with an approved fire stop system in accordance with NFPA 101 Life Safety Code (2012 Edition) section 300.11 (A). Observations revealed that a 1-inch by 1-inch hole above and a 1-inch by 2-inch hole underneath three armored clad wires. Additionally, five cat wires penetrating the fire barrier above the fire doors on the 3rd floor near the soiled linen room were not sealed with a fire stop system and on a ½-inch by ¼-inch hole where three armor cad wires penetrated the fire barrier above the fire doors on the 2nd floor near the soiled linen room. 93 residents have the potential to be affected. Correct Fire rated Caulk was filled in the above mentioned holes (See attached pictures) and a full audit above all fire doors were done to ensure no penetrations, and no additional penetrations were found.	08/28/2025

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

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COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755

(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
K0163 SS = F	Continued from page 1 residents and was evidenced by the following: Observations on 07/31/25 from 11:45 AM to 3:00 PM revealed that a 1-inch by 1-inch hole above and a 1-inch by 2-inch hole underneath three armored clad wires. Additionally, five cat wires penetrating the fire barrier above the fire doors on the 3rd floor near the soiled linen room were not sealed with a fire stop system and on a ½-inch by ¼-inch hole where three armor cad wires penetrated the fire barrier above the fire doors on the 2nd floor near the soiled linen room. During an interview at the time of observation, the U.S. FOIA (b) (6) confirmed that the holes on the 2nd and 3rd floor smoke barriers above the smoke barrier doors. NJAC 8:39-31.2(e)	K0163	Continued from page 1 The Maintenance Director will audit all fire doors once weekly for 1 month and then twice monthly for 2 months to ensure no penetrations. The results of the audits will be discussed quarterly by the Quality Assurance and Performance Improvement Committee	
K0341 SS = F Bldg. 01	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure low voltage wiring was protected in conduit below seven feet in accordance with NFPA 70 National Electrical Code (2011 Edition) section 760.130 (B) (1). This deficient practice had the potential to affect all 159 residents and was evidenced by the following: An observation on 07/31/25 at 12:27 PM revealed low voltage wiring for the fire alarm panel was not protected below seven feet.	K0341	K0341 In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. Observation revealed low voltage wiring for the fire alarm panel was not protected below seven feet and was not secured in conduit. All patients have the potential to be affected. Wire was secured and covered with conduit as per regulation. See attached picture confirmation. Maintenance Director/Designee to perform a facility wide audit to ensure that all wires requiring conduit are in place and properly protected throughout the facility. The audits will be weekly x4 weeks, then monthly x2 months. The results of the audits will be discussed quarterly by the Quality Assurance and Performance Improvement Committee.	08/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755

(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
K0341 SS = F Bldg. 01	Continued from page 2 During an interview at the time of observation, the U.S. FOIA (b) (6) confirmed the low voltage wire was not secured in conduit. NJAC 8:39-31.2(e) NFPA 70	K0341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	**1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755**

(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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/31/25. The facility was found to be in compliance with 42 CFR 483.73	E0000		09/30/2025

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 11/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD , TOMS RIVER, New Jersey, 08755

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 11/15/2025 in relation to the 7/31/2025 Life Safety Code survey. The facility was found to be in 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.	K0000		

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