STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 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
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00157345 NJ00157989 NJ00160592 NJ00160709 NJ00164249 NJ00166068 NJ00166892 NJ00168171 Survey Dates: 02/05/24 through 02/08/24. Survey Census: 141 Sample Size: 28 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.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		3/15/24

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

Electronically Signed | 02/22/2024

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F 609	Continued From page 1 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, document review, and facility policy review, the facility failed to notify the State Survey Agency (SSA) within 24 hours of an allegation of [NJ Ex Order 26] in which 12 tablets for one of one Resident (R) 191's NJ Ex Order 26.4b1 medication was removed from the medication's bingo card and replaced with another pill of similar size but a different color. The facility failed to notify the SSA until two days and 10 hours after the allegation of NJ Ex Order 26.4b1 [redacted] was brought to the US FOIA (b)(6) attention. Findings include: Review of the facility's investigative document, provided by the facility, revealed that on the [NJ Exec Order] unit on [redacted] at 7:00 AM, two nurses,	F 609	Residents affected by deficient practice: • The facility failed to notify the State Survey Agency (SSA) within 24 hours of an allegation of [NJ Ex Order 26] in which 12 tablets for one of one Resident (R) 191's [NJ Ex Order 26.4b1] [redacted] medication was removed from the medication's bingo card and replaced with another pill of similar size but a different color. The facility failed to notify the SSA until two days and 10 hours after the allegation of NJ Ex Order 26.4b1 [redacted] was brought to the NJ Exec Order 26.4b1 ([US FOIA (b)] [redacted]'s attention.	

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F 609	Continued From page 2 Licensed Practical Nurse (LPN) 1 and LPN2, reported immediately to the US FOIA (b) that 12 tablets from R191's NJ Ex Order 26.4b1 bingo card had been removed and replaced with 12 tablets of similar size but different color. The back of the card showed that for 12 bubbles, the bubble had been sliced open, the NJ Ex Order 26.4b1 removed and replaced with another pill, then taped to close the bubble. The NJ Ex Order 26.4b1 NJ Exec Order 2 bingo card had been received from the pharmacy on NJ Exec Order 26.4b. Review of the facility's investigative file revealed a document titled "Reportable Event Record/Report" to the New Jersey (NJ) Department of Health Complaint unit, indicated that the event occurred on NJ Ex Order 26.4b1 at 7:00 AM and was reported on NJ Ex Order 26.4b1 at 5:30 PM. The document indicated 12 tablets of R191's NJ Ex Order 26.4b1 medication bingo card had bubbles that had been sliced open and the NJ Ex Order 26.4b1 medication had been removed, replaced with a pill of similar size but different color and the bubble taped over. The report was submitted to the NJ Complaint unit by the US FOIA (b) on NJ Ex Order 26.4b1 at 5:30 PM, which was two days and 10 hours after the US FOIA (b) had been notified by LPN1 and LPN2 of the missing NJ Ex Order 26.4b1 medication. During an interview on 02/07/24 at 11:04 AM, LPN1 stated that on NJ Ex Order 26.4b1 at 7:00 AM, she was the oncoming nurse and when she counted the NJ Ex Order 26.4b1 with LPN2, she noticed that R191's bingo card looked different. She stated she turned the card over and saw that for 12 bubbles, there was tape over the bubble and that a pill of different color, but similar size had been replaced in the bubble. LPN1 stated that she and LPN2 reported the incident to US FOIA (b) immediately.	F 609	Identify those individuals who could be affected by the deficient practice: • Resident (R) 191 was assessed for any adverse effects with NJ Ex Order 26.4b1. Patient current bingo card was not touched • All residents have the potential to be affected. What corrective action will be accomplished for those residents affected by the deficient practice: • US FOIA (b)(6) were educated on the facility's policy and on the reporting requirements per regulation by the Regional Director. • All facility nursing staff were re-educated on the facility's policy and on the reporting requirements per regulation by the Administrator and DON. Measures or systemic changes to ensure that the deficiencies will not recur: • The Administrator/ Designee to conduct compliance audits of all reportable events. • The audits will be one-time weekly x4 weeks then two times 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.	

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F 609	Continued From page 3 During an interview on 02/07/24 at 11:14 AM, the US FOIA (b)(6) confirmed that the reporting to the SSA was two days late. He stated that he thought the [redacted] was reporting to the SSA and the [redacted] thought the US FOIA (b)(6) was reporting to the SSA. The US FOIA (b)(6) stated that he was aware that the federal regulation and facility's policy indicated that it should have been submitted to the SSA within 24 hours. Review of the facility's policy titled, "Controlled Substances," dated 10/23, revealed "...9. Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. 10. The Director of Nursing Services shall investigate any discrepancies in narcotics reconciliation to determine the cause an identify any responsibility parties ..." Review of the facility's policy titled, "Abuse and Neglect-Clinical Protocol," dated 01/23, revealed "Definitions. 1. Abuse ...the deprivation by an individual ...of goods or services that are necessary to attain or maintain physical ...well-being ..." Review of the facility's policy titled, "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," dated 10/23, revealed "Policy Statement, Residents have the right to be free from abuse ...misappropriation of resident property ...Investigation Allegations: 1. The administrator ...immediately reports his or her suspicion to the following ...agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility ...2. Immediately is	F 609		

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F 609	Continued From page 4 defined as: a. within two hours of an allegation involving abuse ...b. within 24 hours of an allegation that does not involved abuse ..." NJAC 8:39-9.4(f)	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		3/15/24

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F 655	Continued From page 5 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure the resident's baseline care plan contained the care and services required for two of two residents (Resident (R) 125 and R134) of 28 sampled residents, required upon admission to the facility. In addition, the facility failed to provide the summary of care to the resident and representative at the care plan meeting that was conducted after the admission Minimum Data Set (MDS) was completed. Findings include: 1. Review of R125's "Face Sheet" in the electronic medical record (EMR) under the "Profile" tab revealed R125 was admitted on NJ Ex Order 26.4b1 . During an observation and interview on 02/05/24 at 12:06 PM, R125 received NJ Ex Order 26. through a NJ Ex Order 26.4b1. R125 stated that he didn't NJ Ex O but started NJ Ex Order 26.4b1 at the hospital and since being admitted to the facility.	F 655	F 655 Baseline Care Plans. Residents affected by deficient practice: The facility failed to ensure the resident baseline care plans contained care and services required upon admission and failed to provide the summary of care to residents and representative at the care plan meeting for 2 of 2 residents (Resident #125 and resident #134) Identifying other Residents who could be affected by the deficient practice: • Residents that require Baseline Care plans have the potential to be affected. • The DON reviewed residents #125 and #134 medical records and implemented a Baseline Care plan and provided a copy to the resident and resident representative. Measures or systemic changes to ensure that the deficiencies will not recur: • The facility's policies and	

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F 655	Continued From page 6 During an interview on 02/06/24 at 3:06 PM, US FOIA (b)(6) printed R125's "Baseline care plan" and R125's admission "MDS" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4b1 which revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex of 15 which indicated that R125's NJ Ex Order 26.4b1 . Review of R125's "Baseline care plan section 3. Health Conditions," provided by the facility and dated NJ Ex Order 26.4b1, did not address R125's use of NJ Ex Order 26.4 SWLTC confirmed that the baseline care plan did not address R125's use of NJ Ex Order 26.4 During the interview on 02/06/24 at 3:06 PM, US FOIA (b)(6) stated that the care plan meeting was held on NJ Ex Order 26.4b1 and that R125's NJ Ex Or attended the meeting. Review of R125's "Baseline care plan summary section 5. Summary and signatures," provided by the facility and dated NJ Ex Order 26.4b1, revealed "B. Signature of Resident and Representative, 1. Resident signature and date" indicated "Reviewed and copy provided and 2. Representative signature and date" indicated, "Reviewed and copy provided." The document did not contain the signatures of either the resident or the representative. During an interview on 02/07/24 at 12:47 PM, R125's family member (F) 1 stated that she remembered the meeting but was not given a summary of his care or what they would be doing. F1 stated that if they had given her a document, she would have read it. She stated that they just talked with R125 and her.	F 655	Procedures on Baseline Care plan and was reviewed with US FOIA (b) all licensed nursing staff. With Emphasis on care services required upon admission and ensuring a copy is provided to the resident and or resident representative. Monitoring the continued effectiveness of the systemic change: • The DON/Unit Manger/Designee will conduct audits of all residents that require Baseline Care plans. Audits will be completed weekly X 4 weeks then monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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F 655	Continued From page 7	F 655		

During an interview on 02/07/24 at 2:34 PM, US FOIA provided a "US FOIA note, dated NJ Ex Order 26.4b1, which indicated that F1 was provided copies of R125's care plan. US FOIA (b)(6) confirmed that the SW note was not written until today and that the was not given the care plan until today.

2. Review of R134's "Face Sheet" in the "Profile" tab of the EMR revealed that R134 was admitted on NJ Ex Order 26.4b1. Review of R134's admission "MDS" with an ARD of NJ Ex Order 26.4b1 revealed a BIMS score of NJ Ex of 15 which indicated that R2's NJ Exec Order 26.4b was NJ Ex Order 26.4b1.

During an interview on 02/06/24 at 3:25 PM, US FOIA (b)(6) printed R134's "Baseline care plan," which indicated R124's use of NJ Ex Order 26.4 and NJ Ex Order 26.4b1 due to NJ Ex Order 26.4b1 NJ Ex Order 26.4b1) were not indicated on the baseline care plan. The US FOIA (b)(6) confirmed that the "baseline care plan" sections A through I were blank and did not contain any information about the care and services R134 required which included the use of NJ Ex Order 26.4 NJ Ex Order 26.4b1, and that NJ Ex O was still experiencing NJ Ex Order 26.4b due to NJ Ex Order.

Review of R134's "Baseline care plan summary section 5. Summary and signatures" provided by the facility, dated NJ Ex Order 26.4b1, revealed "B. Signature of Resident and Representative, 1. Resident signature and date" indicated "Reviewed and copy provided and 2. Representative signature and date" indicated, "Reviewed and copy provided." The document did not contain the signatures of either the resident or the representative.

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F 655	Continued From page 8 Review of "Care plan meeting attendance sheet," provided by the facility and dated [NJ Ex Order 26.4b1], revealed that R134's [NJ Ex Order 26.4b1] attended the meeting. There was no documentation in the "[US FOIA] notes" that R134's [NJ Ex Order 26.4b1] had received the summary of R134's care. During an interview on 02/07/24 at 9:51 AM, [US FOIA] was shown R134's "Baseline care plan" section three Health Conditions for categories A through I and confirmed these sections were blank. Review of the facility's policy titled, "Care Plans-Baseline," dated 01/24, revealed "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission ...2. The Interdisciplinary Team will review the healthcare practitioner's orders ...and implement a baseline care plan to meet the resident's immediate care needs ...4. The resident and their representative will be provided a summary of the baseline care plan ..." NJAC 8:39-11.1 NJAC 8:39-11.2	F 655		
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 by:	F 677		3/15/24

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F 677	Continued From page 9 Based one observation, interview, record review, and facility policy review, the facility failed to ensure that residents who NJ Ex Order 26.4b1 their own Activities of Daily Living (ADLs) regarding NJ Ex Order 26.4 and NJ Ex Order 26.4b1 was provided by facility staff for two of two residents (Residents (R)193 and R194) of 28 sampled residents. Findings include: 1. Review of R193's "Face Sheet" in the electronic medical record (EMR) under the "Profile" tab revealed R193 was admitted on NJ Ex Order 26.4b1. No Minimum Data Set (MDS) information available. Observation and interview on 02/05/24 at 11:50 AM, revealed R193 had a NJ Ex Order 26.4b1 that was approximately NJ Ex Order 26.4b1 and his NJ Ex Order 26.4b1 with a NJ Ex Order 26.4b1. Immediately at the time of this observation, Registered Nurse (RN) 1 entered the room and confirmed R193 should have been NJ Ex Order 26.4 and his NJ Ex Order 26.4b1. Review of R193's "Care plan" from the "Care plan" tab in the EMR with a date of NJ Ex Order 26.4b1, revealed a problem that R193 has an ADL NJ Ex Order 26.4b1 with interventions .NJ Ex Order 26.4b1: Not attempted due to medical/safety concern. 2. Review of R194' "Face Sheet" in the EMR under the "Profile" tab revealed R194 was admitted on NJ Ex Order 26.4b1. No MDS information available. Observation and interview on 02/06/24 at 10:44 AM, revealed R194 had an approximate NJ Ex Order 26.4b	F 677	F677 - ADL Care Provided for Dependent Residents Residents affected by deficient practice: The facility failed to consistently provide appropriate Activities of Daily Living (ADLs) care, for residents who were NJ Ex Order 26.4b1 on staff assistance for care, by failing to provide: a) NJ Ex Order 26.4 and b) NJ Ex Order 26.4b1 This deficient practice was identified for 3 of 5 dependent residents (Resident #193, #194) Identify those individuals who could be affected by the deficient practice: • All dependent residents have the potential to be affected by the deficient practice. • The residents affected were monitored for any adverse effects of the deficient practice NJ Ex Order 26.4b1 . What corrective action will be accomplished for those residents affected by the deficient practice: • Resident #s 193, 194, was NJ Ex Order 26.4b1 and was NJ Ex Order 26.4b1 immediately; NJ Exec Order 26.4b1 noted. • All nursing staff re-educated on facility policy for “Activities of Daily Living (ADL) Support”, and Bathing, with emphasis on providing showers, providing grooming, and getting residents out of bed consistently. Measures or systemic changes to ensure that the deficiencies will not recur: The DON/Unit Manger/Designee will	

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F 677	Continued From page 10 NJ Ex Order 26.4b1. R194 stated at this time that he preferred to be NJ Ex Order 26.4b1 but he did not have a NJ Ex Order Review of R194's "Care plan" from the "Care plan" tab in the EMR with a date of NJ Ex Order 26.4b1, revealed a problem that R194 had an ADL NJ Ex Order 26.4b1 with interventions ..NJ Ex Order 26.4b1: Not attempted due to medical/safety concerns. During an interview on 02/8/24 at 1:27 PM, Licensed Practical Nurse (LPN) 4 stated that the resident should have been NJ Ex Order 26.4 every day if he wanted to be NJ Ex Order 26.4 LPN 4 confirmed that the resident had NJ Ex Order 26.4b1 since admission and only one NJ Ex Order 26.4b1 When LPN 4 reviewed R194's bathing documentation, she stated that she found that R194's "NJ Ex Order 26.4b1" had been marked "as needed" so LPN 4 changed R194's NJ Ex Order 26.4b1 so that it would occur two times per week. LPN4 stated this explained why R194 was not getting NJ Ex Order 26.4b1 or NJ Ex Order 26.4b1 Review of the facility's policy titled, "Activities of Daily Living (ADLs), Supporting, Documenting," dated 01/23, revealed "Resident will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Resident who are unable to carry out activities of daily living independently will receive the services necessary to maintain good ...grooming ad person ...hygiene ...6. Interventions to improve or minimize a resident's functional abilities will be in accordance with the resident's assessed needs, preferences, stated goals and recognized standards of practice. 8. Documentation will be completed in the Point of Care ADL documentation once care	F 677	conduct audits of 8 random residents that require ADL care with an emphasis on nail care, grooming, showering, getting. Audits will be completed weekly X 4 weeks then monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process to ensure compliance and reassessed for further action.	

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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
F 677	Continued From page 11 is completed each shift." NJAC 8:39-4.1(a)22	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, the facility failed to encourage and arrange NJ Ex Order 26.4b1 for two of two residents (Resident (R) 46 and R128) of 28 sampled residents to NJ Ex Order 26.4b1 of their choosing. Findings include: 1. During an interview on 02/05/24 at 2:37 PM, R46 stated that he used to go to the NJ Exec Order 2 floor for NJ Ex Order 26.4b1 but he was told that they stopped NJ Ex O floor residents from mingling with NJ Exec Order 2 floor residents. R46 stated that he NJ Ex Order 26.4b1, and that he had not been able to go to NJ Ex Order on the NJ Exec Order 26 floor and that he NJ Ex Order 26.4b1. Review of R46's "Face Sheet" in the electronic medical record (EMR) under the "Profile" tab	F 679	Residents affected by deficient practice: The facility failed to encourage and arrange NJ Ex Order 26.4b1 for two of two residents, Resident (R) 46 and (R) 128, of 28 sampled residents to NJ Ex Order 26.4b1 of their choosing. Identify those individuals who could be affected by the deficient practice: • Resident (R) 46 and (R) 128 were assessed for any NJ Exec Order 26.4b1 with NJ Ex Order 26.4b1 The Activity Programing has been reviewed for both residents and updated to meet each resident's needs. • All residents have the potential to be affected. • All Care plans have been	3/15/24

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	315265	A. BUILDING _____ B. WING _____	C 02/08/2024

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F 679	Continued From page 12 revealed R46 was admitted to the facility on NJ Ex Order 26.4b1. Review of R46's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4b1 under the "MDS" tab in the EMR revealed a Brief Interview for Mental Status (BIMS) score of NJ Ex out of 15 which indicated R46's NJ Ex Order 26.4b1. Review of the admission "MDS" section for Preferences for NJ Ex Order 26.4b1 revealed documentation that it was very important for R46 to NJ Ex Order 26.4b1, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. Review of R46's "Care Plan" in the EMR under the "Care Plan" tab revealed a goal that R46 would NJ Ex Order 26.4b1 three-five times per week with interventions which included NJ Ex Order 26.4b1, engaging with NJ Ex Order 26 staff, and assisting in NJ Ex Order 26.4b1 to NJ Ex Order 26.4b1 During an interview on 02/05/24 at 4:30 PM, R46's comment about not being able to go to the NJ Exec Order 2 floor to attend NJ Ex Order was shared with the facility's US FOIA (b)(6) who stated that he would follow up with the US FOIA (b)(6). 2. During an interview on 02/06/24 at 1:01 PM, R128's family member (F) 3 stated that R128 wanted to go to the NJ Ex Order 26.4b1 but staff did not NJ Ex Order 26.4b1. Review of R128's "Face Sheet" in the EMR under the "Profile" tab revealed R128 was admitted to the facility on NJ Ex Order 26.4b1.	F 679	reviewed and updated as needed to reflect each resident's individual interests/needs. What corrective action will be accomplished for those residents affected by the deficient practice: • Activity Staff were all re-educated by the administrator on the expectation of ensuring activities meet interests/needs of each resident through care plans, assessments, and programs. • All activities staff were re-educated by the Administrator on offering all residents the opportunity to attend activities even if they are scheduled on different units. • All activities staff were re-educated by the Administrator on the facility's policy titled "Meaningful Resident Activities". Measures or systemic changes to ensure that the deficiencies will not recur: • The Activities Director/ Designee to conduct compliance audits of assessments, participation, and documentation. • The audits will be two times weekly x4 weeks then two times 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	

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F 679	Continued From page 13 Review of R128's admission "MDS" with an ARD of NJ Ex Order 26.4b1 under the "MDS" tab in the EMR revealed a BIMS score of NJ Ex out of 15 which indicated R128's NJ Ex Order 26.4b1. Review of the section for Preferences for NJ Ex Order 26.4b1 revealed documentation that it was "very important for [R128] to NJ Ex Order 26.4 , be NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , go outside to get fresh air and participate in NJ Ex Order 26.4b ..." Review of R128's "Care Plan," dated NJ Ex Order 26.4b1 in the EMR under the "Care Plan" tab, revealed a goal for R128 was to maintain involvement in NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 ....with interventions to include "Establish and record [R128's] prior level of NJ Ex Order 26.4b1 and interests, modify daily schedule, treatment plan to accommodate NJ Ex Order 26.4b1 as requested by [R128], Staff to introduce to peers ...and encourage/facilitate NJ Ex Order 26.4b1 such as NJ Ex Order 2 NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 and NJ Ex Order 2 ..." During an interview on 02/08/24 at 11:25 AM, the US FOIA (b)(6) stated that she had no documentation whether R46 and R128 were asked to NJ Ex Order 26.4b1 and refused. The US FO stated that each day she delivered the "Daily Chronical" a one-page document that indicated the activities for the day, to each resident's room. She stated that the resident could review the activities for the day and if the resident wanted to NJ Ex Order 26.4b1, the resident was to ask staff to NJ Ex Order 26.4b1. The US FO stated that she had no documentation to show that R46 or R128 was asked if they wanted to NJ Ex Order 26.4b1 of their preference and whether they attended or refused to attend.	F 679	submission and reporting.	

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F 679	Continued From page 14 Review of the facility's policy titled, "Meaningful Resident Activities," dated 01/23, revealed "To provide meaningful activities ...Organization Plan for universal approach to Activities in a facility ...All department will be responsible for assistance to and from scheduled activity programs ..."	F 679		
F 804 SS=E	NJAC 8:39-7.3 Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review for two of three units ([redacted] unit and [redacted] unit) and five residents (Resident (R) 17, R196, R125, R2, R18) of 28 sampled residents revealed the food served was bland and residents did not receive salt, pepper, or [redacted] to season their food after being served. Findings include: Review of R17's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] revealed R17 had a Brief	F 804	F804- Residents affected by deficient practice. Based on observation, interview, and record review for two of three units ([redacted] unit and [redacted] unit) and five residents (Resident (R) 17, R196, R125, R2, R18) of 28 sampled residents revealed the food served was bland and residents did not receive salt, pepper, or [redacted] to season their food after being served. Identify those individuals who could be	3/15/24

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F 804	Continued From page 15 Interview for Mental Status (BIMS) score of NJ Ex out of 15 which indicated R17 was NJ Ex Order 26.4b1 During the initial tour of the facility on 02/05/24 at 11:39 AM, R17 stated, "The food NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 ." During an interview on 02/05/24 at 11:57 AM, R196 stated that the food was salty, especially the gravy. Review of R125's admission "MDS" with an ARD of NJ Ex Order 26.4b1 revealed a BIMS score of NJ Ex of 15 which indicated that R125's NJ Ex Order 26.4b1. During an interview on 02/05/24 at 12:08 PM, R125's family member (F) 1 stated that the facility used to put salt, pepper packets, and butter on the resident's trays but did not do that anymore. F1 stated that the mashed potatoes tasted bland. Observation and interview on 02/05/24 at 12:14 PM revealed the NJ Exec-floor lunch tray cart had no salt or pepper packets on the residents' trays. Certified Nurse Aide (CNA) 1 who was observed delivering lunch trays to residents on the NJ Exec floor, confirmed that there were no salt or pepper packets on residents' trays. Review of R2's admission "MDS" with an ARD of NJ Ex Order 26.4b1 revealed a BIMS score of NJ Ex of 15 which indicated that R2's NJ Ex Order 26.4b1. During an observation and interview on 02/05/24 at 12:25 PM, R2 was observed eating the soup on NJ Ex lunch tray. R2 stated that the soup tasted warm not hot. NJ Ex Or stated that the mashed potatoes tasted bland.	F 804	affected by the deficient practice: " All residents have the potential to be affected. " Resident (R) 17, R196, R125, R2, R18 were monitored for any adverse effects with NJ Ex Order 26.4b1 What corrective action will be accomplished for those residents affected by the deficient practice: " The Regional Food Service Director re-educated all dietary staff on the importance of ensuring food has acceptable flavor and appearance while following the recipes to ensure the food is palatable. " Salt, Pepper, or NJ Ex Order 26.4b1 will be provided to the patients who request it with additional packets readily available on each unit as well. Measures or systemic changes to ensure that the deficiencies will not recur: " The Food Service Director/Designee will conduct compliance audits on food palatability and that the residents who request Salt, Pepper, or NJ Ex Order 26.4b1 receive it on the tray. " Will review with the Resident Menu Planning Committee for each month x3 months to ensure taste has been better. " The audits will include 3 trays, two-times per week x4 weeks, and then 3 trays two-times monthly x2 months. Results of audits will be reviewed at the Quarterly Quality Assurance and Performance	

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F 804	Continued From page 16 During an interview on 02/05/24 at 12:25 PM, R18 stated that the facility food was '[NJ Ex Order 26.4b] [NJ Ex Ord] said that the dietary department cooked the meat, usually chicken or turkey, until it was dry. R18 said that the kitchen served the same vegetables on a regular basis, usually peas and carrots. [NJ Ex Orde] said that sometimes they would serve carrots that were almost raw, and [NJ Ex Order 26.4] for [NJ Ex O] R18 stated that the kitchen often did not cook what was posted on the menu. [NJ Ex Or] said that sometimes the kitchen says that the meal was not cooked according to the menu because the delivery truck had not delivered the correct products. [NJ Ex O] stated that the kitchen often served items that local people did not like, not '[NJ Ex Order 26.4] meals. During an observation, alongside the [US FOIA (b)(6)] [redacted], the US FOIA (b)(6) [redacted], and the US FOIA (b)(6) on 02/07/24 at 12:05 PM, no salt or pepper packets were placed on trays during tray line lunch service. The packets were available on the tray line in the same caddy as the ketchup. During an interview at 12:10 PM, the US FOIA (b)(6) stated the previous dietitian did not want the seasoning packets on the trays. During an observation on 02/07/24 at 12:41 PM, a test tray was evaluated for palatability for the NJ Exec Order 26.4b1 unit. The test tray was the last tray delivered to the [NJ Exec Orde] unit. The meal consisted of meatballs, brown gravy, green beans, and chicken vegetable soup. The soup was homemade and well flavored, the meatballs were hot but had no flavor. The brown gravy was bland as well. The tray did not include salt and pepper.	F 804	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 804	Continued From page 17 During an observation on 02/07/24 at 12:58 PM, a second test tray was evaluated for palatability on the [NJ Exec Order] unit. The meal was an alternate meal on the menu. Lunch alternate included veal parmesan with pasta sauce and cheese, and mixed vegetables that included green beans, zucchini, and carrots. The veal was hot but had no flavor, the red sauce was not seasoned. The vegetables had no flavor and were overcooked. The tray did not include salt and pepper. During an interview on 02/08/24 at 9:30 AM, the [US FOIA (b)(6)] revealed he followed the menu as it was written. When asked if he seasoned the pasta sauce the day before, he stated he had seasoned the first pan of sauce, however more residents ordered the alternate than normal. He stated he opened a can of marinara sauce and did not have time to season it before lunch. Review of the recipes for Swedish Meatballs revealed the [US FOIA (b)(6)] should have added mushrooms and onions to the meal. The recipe for the meatballs indicated they were to be home made and the facility used pre-made meatballs. During an interview on 02/08/24 at 9:45 AM, the [US FOIA (b)(6)] revealed he was not aware the red sauce had not been seasoned.	F 804		
F 880 SS=E	NJAC 8:39-17.4(a)2,(e) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		3/15/24

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F 880	Continued From page 18 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 19 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews, and facility policy review, the facility failed to follow NJ Ex Order 26.4b1 procedures during a NJ Ex Order 26.4b1 process, while delivering a meal tray to a resident in NJ Ex Order 26.4b1, and during room cleanings for residents in NJ Ex Order 26.4b1 for four of seven residents (Resident (R)86, R345, R134, and R194) reviewed for NJ Ex Order 26.4b1 standards of 28 sampled residents. Findings include:	F 880	F880 – Infection Prevention & Control Residents affected by deficient practice: The facility failed to follow NJ Ex Order 26.4b1 procedures during a NJ Ex Order 26.4b1 process, while delivering a meal tray to a resident in NJ Ex Order 26.4b1 and during room cleaning for residents with NJ Ex Order 2 [redacted]. This deficient practice was identified for 4 of 7 residents (Residents #86 #345, #134 and # 194) reviewed for NJ Ex Order 26.4b1.	

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F 880	Continued From page 20 1. Review of R86's undated "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) revealed R86 was readmitted to the facility on NJ Ex Order 26.4b1 with diagnoses of NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 . Review of R86's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Ex Order 26.4b1 revealed R86 had a "Brief Interview for Mental Status (BIMS)" score of NJ Ex out of 15 which indicated R86 was NJ Ex Order 26.4b1 . During an observation of a NJ Ex Order 26.4b1 to R86's NJ Ex Order 26.4b1 on 02/08/24 at 10:59 AM, Licensed Practical Nurse (LPN) 1 removed the NJ Ex Order 26.4b1 and discarded. The nurse removed her gloves and washed her hands. LPN1 donned clean gloves and NJ Ex Order 26.4b1 as ordered. Then the nurse NJ Ex Order 26.4b1 using one corner of a clean NJ Exec and then using the same NJ Exec the nurse turned the NJ Exec to a corner that was not used and NJ Ex Order 26.4b1 again. LPN1 applied NJ Ex Order 26.4b1, then applied NJ Ex Order 26.4b1, and covered the NJ Ex Order 26 with an NJ Ex Order 26.4b1. LPN1 did not change her gloves after NJ Ex Order 26.4b1 nor prior to NJ Ex Order 26.4b1 with a new NJ Ex Order 26.4b1 During an interview on 02/08/24 at 3:15 PM, LPN1 stated, "I forgot to change my gloves before I put the NJ Ex Order 26.4b1 on again." During an interview on 02/08/24 at 4:17 PM, the US FOIA (b)(6)) confirmed the nurse should have changed her gloves after the nurse NJ Ex Order 26.4b1 and before the nurse applied	F 880	Identify those individuals who could be affected by the deficient practice: • All residents who receive wound care. • All residents on isolation precautions have the potential to be affected by the deficient practice. • The residents affected were monitored for any adverse effects of the deficient practice NJ Ex Order 26.4b1 . What corrective action will be accomplished for those residents affected by the deficient practice: • Resident #86 had NJ Ex Order 26.4b1 administered; NJ Ex Order 26.4b1 noted. • The US FOIA was immediately educated, and competency was completed for completing wound treatments. • All licensed nursing staff re-educated on facility policy for “Pressure Ulcer/Skin breakdown clinical protocol”, and “wound care” and the importance of disinfecting the surface to be used, maintaining a clean field, providing a protective barrier, and hand washing. • All staff re-educated on facility policy “Isolation precautions.” • All Housekeeping staff re-educated on facility policy “Cleaning of patients rooms with C-Diff”. Measures or systemic changes to ensure that the deficiencies will not recur: The DON/Unit Manger/Designee will conduct audits of 8 random nurses for	

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F 880	Continued From page 21 the new [redacted] 2. Review of R345's undated "Admission Record" located under the "Profile" tab in the EMR revealed R345 was admitted to the facility on [redacted] with diagnoses of [redacted], [redacted], and [redacted]. Review of the "[Name] Nursing Comprehensive Assessment," dated [redacted], revealed R345 was [redacted], [redacted] and [redacted]. The admission "MDS" had not been completed due to new admission on [redacted]. During an observation on 02/06/24 at 12:30 PM, Certified Nursing Assistant (CNA) 1 donned personal protective equipment (PPE) before he went into R345's room. R345 was in [redacted]. CNA proceeded to walk into the resident's room for a few minutes and then returned to the hallway with PPE still on and obtained the lunch tray for R345. CNA1 took the lunch tray into R345's room. CNA1 removed PPE prior to coming back into the hallway but was not observed to wash his hands prior to leaving the room. During an interview on 02/06/24 at 2:51 PM, CNA1 stated, "I didn't realize I didn't wash my hands, but you are right I should have done this before I came out of the room." During an interview on 02/08/24 at 4:17 PM, the [redacted] confirmed the CNA should have washed his hands after he removed his PPE and before coming out of the resident's room. 3. Observation on 02/05/24 at 3:43 PM revealed	F 880	competency of wound treatments. Audits will be completed weekly X 4 weeks then monthly x 2 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly Meetings over the duration of the audit process to ensure compliance and reassessed for further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING _____ B. WING _____	C 02/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 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
F 880	Continued From page 22	F 880		

NJ Ex Order 26.4b1 signs posted on the outside of R134 and R194's bedroom doors.

During an interview on 02/05/24 at 10:59 AM, Registered Nurse (RN) 1 stated that both R134 and R194 were in NJ Ex Order 26.4b1 due to having NJ Ex Order 26.4b1 (NJ Ex Order 26.4b1). RN1 stated that R134 was receiving NJ Ex Order 26.4b1 NJ Ex O) oral tablet, and her last dose of the NJ Ex Order 26.4b1 would have been NJ Ex Order 26.4b1 . RN1 stated that R194 had already completed the NJ Ex Order 26.4b1 to treat the NJ Ex Order .

During an interview on 02/06/24 at 10:06 AM, in the presence of the US FOIA (b)(6) and US FOIA (b)(6) who was observed sweeping and mopping floors of residents' rooms on the first floor, stated that when she mopped R134 and R194's bedroom and bathroom floors, she would use the same mop water and mop that she was using on every other resident's floors.

During an interview on 02/06/24 at 10:06 AM, the US FOIA confirmed that R134 and R194 were in NJ Ex Order 26.4b for NJ Ex Order and that the housekeeper would have used the same mop water and mop that the housekeeper used on other residents' floors. The US FOI stated that the product the housekeeper put in the mop water was called NJ Ex Order 26.4b (cleaning chemical).

On 02/06/24 at 10:30 AM, the US FOIA provided the NJ Ex Order 26.4b Material Safety Data Sheet (MSDS) which revealed that NJ Ex Order 26.4b did not kill the NJ Ex Order . The US FOI stated that he spoke to the facility's US FOIA (b)(6) and was

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F 880	Continued From page 23	F 880		

informed to use bleach in the mop water when mopping the floors in residents' rooms who had [redacted]. During further interview with the [redacted] he stated that he didn't know until today that the product, [redacted] did not kill [redacted]. The [redacted] stated that for those two residents' rooms, the housekeeper would have to use different water with bleach in it at a 10:1 ratio, a different bucket, and a different mop. When asked how the housekeeper would measure the bleach to create a 10:1 ratio, the [redacted] stated that he would have to get a measuring cup to measure the bleach and that he would have to instruct the housekeeper how to create a 10:1 ratio.

During an interview on 02/06/24 at 11:16 AM, the [redacted] stated after reviewing the facility's Infection Control Surveillance logs for [redacted] and [redacted], that R194 was admitted on [redacted]. The [redacted] stated that R194's [redacted] in the hospital, dated [redacted], indicated [redacted] and R194 was placed in [redacted] when admitted to the facility on [redacted]. The [redacted] stated that R194 had completed the [redacted]

The [redacted] stated that R134 was admitted from the hospital on [redacted] and that R134's [redacted], dated [redacted], showed [redacted]. R124 was started on [redacted] every six hours on [redacted] and the [redacted] would continue until [redacted].

The [redacted] stated that he had instructed the [redacted] before today, that when a resident was in [redacted] and had [redacted], housekeeping must use bleach in the mop water and to use a clean bucket and mop for these rooms.

Review of the undated facility's policy titled,

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F 880	Continued From page 24 "Cleaning of Patient Rooms identified with Clostridioides difficile" indicated, "Before cleaning ...The Sodium Hypochlorite (commonly known in a dilute solution as bleach) disinfectant will be prepared daily ...cleaning will be performed using a 1/10 dilution of Sodium Hypochlorite (Bleach) ...13. Mop the floor. 14. Mop the restroom floor ...Follow these rules, change mop water and mop after every isolation room ..." NJAC 8:39-19.4(a) (m) (n)	F 880		

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	061531	A. BUILDING: _____ B. WING _____	C 02/08/2024

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	S560 1. The facility leadership team has met on an ongoing basis and continues to identify staffing challenges and areas of improvement for licensed and certified needs. Recruitment efforts include online advertisements, local community advertisements, onsite and on the spot interview availability, and continued use of agency staff to supplement. The facility recently started a sponsorship program that pays for individuals to go to school to become Certified Nursing Assistants. The center also utilizes the assistance of nurse management, physical therapist, and occupational therapists along with our Hospice aids to assist with direct care as	3/15/24

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

Electronically Signed | 02/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 08/14/2022 to 08/20/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -08/14/22 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/15/22 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/16/22 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/17/22 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/18/22 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/19/22 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/20/22 had 12 CNAs for 138 residents on the day shift, required at least 17 CNAs. -08/21/22 had 12 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/22/22 had 13 CNAs for 136 residents on the day shift, required at least 17 CNAs.	S 560	directed by the Director of Nursing. 2. All residents have the potential to be affected. 3. The facility has implemented a competitive market rate for nurses and certified nursing aides. The facility continues to utilize online recruitment with immediate interviews and contingency offers. The facility implemented an expediated but robust onboarding process. The facility will use agency staff as needed to meet staffing needs. The facility has a biweekly recruitment call with the corporate recruitment team to look into new areas of opportunity and growth for potential in-house staff. 4. Administrator/Designee will conduct 2 audits of random shifts per week for 4 weeks, then 2 audits monthly for 2 months to ensure adequate staff is scheduled to accommodate resident needs. 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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S 560	Continued From page 2 -08/23/22 had 11 CNAs for 136 residents on the day shift, required at least 17 CNAs. -08/24/22 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs. -08/25/22 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs. -08/26/22 had 13 CNAs for 133 residents on the day shift, required at least 17 CNAs. -08/27/22 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. 2. For the 2 weeks of Complaint staffing from 09/11/2022 to 09/24/2022, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -09/11/22 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs. -09/12/22 had 9 CNAs for 131 residents on the day shift, required at least 16 CNAs. -09/13/22 had 13 CNAs for 131 residents on the day shift, required at least 16 CNAs. -09/14/22 had 10 CNAs for 131 residents on the day shift, required at least 16 CNAs. -09/15/22 had 14 CNAs for 129 residents on the day shift, required at least 16 CNAs. -09/16/22 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs. -09/17/22 had 8 CNAs for 129 residents on the day shift, required at least 16 CNAs. -09/18/22 had 9 CNAs for 127 residents on the day shift, required at least 16 CNAs. -09/19/22 had 10 CNAs for 124 residents on the day shift, required at least 15 CNAs. -09/20/22 had 11 CNAs for 122 residents on the day shift, required at least 15 CNAs. -09/21/22 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -09/22/22 had 11 CNAs for 121 residents on the day shift, required at least 15 CNAs.	S 560		

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S 560	Continued From page 3 -09/23/22 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -09/24/22 had 10 CNAs for 120 residents on the day shift, required at least 15 CNAs. 3. For the 4 weeks of Complaint staffing from 01/01/2023 to 01/28/2023, the facility was deficient in CNA staffing for residents on 28 of 28 day shifts as follows: -01/01/23 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/02/23 had 11 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/03/23 had 12 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/04/23 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/05/23 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/06/23 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/07/23 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/08/23 had 12 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/09/23 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. -01/10/23 had 15 CNAs for 132 residents on the day shift, required at least 18 CNAs. -01/11/23 had 14 CNAs for 140 residents on the day shift, required at least 17 CNAs. -01/12/23 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/13/23 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/14/23 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/15/23 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs.	S 560		

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S 560	Continued From page 4 -01/16/23 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/17/23 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/18/23 had 13 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/19/23 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/20/23 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/21/23 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -01/22/23 had 11 CNAs for 137 residents on the day shift, required at least 17 CNAs. -01/23/23 had 14 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/24/23 had 15 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/25/23 had 14 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/26/23 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/27/23 had 13 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/28/23 had 12 CNAs for 134 residents on the day shift, required at least 17 CNAs. 4. For the 2 weeks of Complaint staffing from 05/07/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -05/07/23 had 12 CNAs for 134 residents on the day shift, required at least 17 CNAs. -05/08/23 had 12 CNAs for 128 residents on the day shift, required at least 16 CNAs. -05/09/23 had 12 CNAs for 127 residents on the day shift, required at least 16 CNAs. -05/10/23 had 12 CNAs for 127 residents on the day shift, required at least 16 CNAs.	S 560		

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S 560	Continued From page 5 -05/11/23 had 12 CNAs for 126 residents on the day shift, required at least 16 CNAs. -05/12/23 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -05/13/23 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -05/14/23 had 12 CNAs for 124 residents on the day shift, required at least 15 CNAs. -05/15/23 had 14 CNAs for 124 residents on the day shift, required at least 15 CNAs. -05/16/23 had 13 CNAs for 124 residents on the day shift, required at least 15 CNAs. -05/17/23 had 12 CNAs for 124 residents on the day shift, required at least 15 CNAs. -05/18/23 had 13 CNAs for 129 residents on the day shift, required at least 16 CNAs. -05/19/23 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs. -05/20/23 had 12 CNAs for 129 residents on the day shift, required at least 16 CNAs. 5. For the 2 weeks of Complaint staffing from 12/10/2023 to 12/23/2023, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -12/10/23 had 16 CNAs for 138 residents on the day shift, required at least 17 CNAs. -12/11/23 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -12/12/23 had 14 CNAs for 138 residents on the day shift, required at least 17 CNAs. -12/14/23 had 14 CNAs for 146 residents on the day shift, required at least 18 CNAs. -12/15/23 had 14 CNAs for 146 residents on the day shift, required at least 18 CNAs. -12/16/23 had 15 CNAs for 146 residents on the day shift, required at least 18 CNAs. -12/17/23 had 13 CNAs for 143 residents on the day shift, required at least 18 CNAs.	S 560		

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S 560	Continued From page 6 -12/18/23 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. -12/19/23 had 16 CNAs for 142 residents on the day shift, required at least 18 CNAs. -12/20/23 had 14 CNAs for 142 residents on the day shift, required at least 18 CNAs. -12/21/23 had 15 CNAs for 142 residents on the day shift, required at least 18 CNAs. -12/22/23 had 17 CNAs for 143 residents on the day shift, required at least 18 CNAs. 6. For the 2 weeks of staffing prior to survey from 01/21/2024 to 02/03/2024, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -01/21/24 had 15 CNAs for 134 residents on the day shift, required at least 17 CNAs. -01/22/24 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. -01/23/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/24/24 had 13 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/25/24 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/26/24 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/27/24 had 14 CNAs for 136 residents on the day shift, required at least 17 CNAs. -01/28/24 had 14 CNAs for 132 residents on the day shift, required at least 16 CNAs. -01/29/24 had 12 CNAs for 130 residents on the day shift, required at least 16 CNAs. -01/30/24 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs. -01/31/24 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -02/02/24 had 13 CNAs for 135 residents on the day shift, required at least 17 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 7 -02/03/24 had 16 CNAs for 135 residents on the day shift, required at least 17 CNAs.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315265 Y1	A. Building B. Wing Y2	4/3/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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	F0609	Correction	ID Prefix	F0655	Correction	ID Prefix	F0677	Correction
Reg. #	483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. #	483.21(a)(1)-(3)	Completed	Reg. #	483.24(a)(2)	Completed
LSC		03/15/2024	LSC		03/15/2024	LSC		03/15/2024
ID Prefix	F0679	Correction	ID Prefix	F0804	Correction	ID Prefix	F0880	Correction
Reg. #	483.24(c)(1)	Completed	Reg. #	483.60(d)(1)(2)	Completed	Reg. #	483.80(a)(1)(2)(4)(e)(f)	Completed
LSC		03/15/2024	LSC		03/15/2024	LSC		03/15/2024
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?
2/8/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061531		4/3/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
2/8/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING **01** B. WING _____	**02/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	**1931 LAKEWOOD ROAD** **TOMS RIVER, NJ 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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 02/06/23. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	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 02/06/24 was found to be in noncompliance 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. Complete Care at Green Acres is a three-story building that was built in 1965. It is composed of Type II protected construction. The facility is divided into 15 - smoke zones. The generator does approximately 70 % of the building per the Maintenance Director. The current occupied beds are 142 of 162.	K 000		
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 observations and interview, the facility	K 347	K347	3/15/24

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

Electronically Signed | 02/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING **01** B. WING _____	**02/08/2024**

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

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K 347	Continued From page 1 failed to ensure smoke detection was installed in rooms open to the corridor in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.1. This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: Observations on 02/06/24 at 1:08 PM revealed no smoke detectors were in the lounge on the third floor and in the lounge on the second floor next to the nurses' stations which were open to the corridors. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the smoke detectors were not installed in the resident lounges. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 347	No smoke detectors were in the lounge on the third floor and in the lounge on the second floor next to the nurses' stations which were open to the corridors. All patients the potential to be affected. - The smoke detectors in the lounge on the third floor and in the lounge on the second floor next to the nurses□ stations were installed by 3/15/2024. - This will be monitored through audits of smoke detectors by the Maintenance Director/Designee. 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. - see attached photos and proof of install report from NJ Ex Order 26.4b1.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		3/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING **01** B. WING _____	**02/08/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	**1931 LAKEWOOD ROAD** **TOMS RIVER, NJ 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
K 372	Continued From page 2 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure fire dampers were inspected every four years in accordance with NFPA 80 Installation, Testing, and Maintenance of Fire Dampers (2010 edition) Section 19.4.1.1. This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: A review of the facility's binder dated 2022 and 2023, provided by the US FOIA (b)(6), revealed the fire dampers were not inspected every four years as required by the Code. An observation on 02/06/24 at 2:10 PM revealed HVAC duct work that was open in the corridor the third floor extending down to the second floor. Looking down in the duct from the third-floor corridor revealed what appeared to be a fire damper separating the two floors. The HVAC duct on the second floor could not be opened because of the trim molding that was installed during renovations. During an interview at the time of observation, the US FOIA (b)(6) could not determine if any fire dampers were present in the HVAC duct but did confirm that no dampers were tested. NJAC 8:39-31.2(e) NFPA 80	K 372	K372 Fire dampers were not inspected every four years as required by the Code. All patients have the potential to be affected. - The HVAC duct will be inspected, and the dampers will be scheduled to be inspected before 3/15/24. - This will be monitored through audits by the Maintenance Director/Designee. - The audits will be monthly x 3 months. The results of the audits will be discussed quarterly by the Quality Assurance and Performance Improvement Committee. - See attached Work inspection report for proof of compliance	
K 511 SS=F	Utilities - Gas and Electric	K 511		3/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315265	A. BUILDING **01** B. WING _____	**02/08/2024**

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

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K 511	Continued From page 3 CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure that nonmetallic-sheathed wiring was either concealed in walls or in conduit in accordance with NFPA 70 National Electrical Code (2011 Edition) Article 334.10 (3). This deficient practice had the potential to affect all 142 residents who resided at the facility. Findings include: An observation on 02/06/24 at 1:01 PM revealed nonmetallic-sheathed wiring (NJ Ex Order 26) was not protected in interior walls or in conduit in the dry sprinkler room. During an interview at the time of the observation, the US FOIA (b)(6) verified the nonmetallic-sheathed wiring (NJ Ex Order 26) was not protected in the walls or in conduit. NJAC 8:39-31.2(e)	K 511	K511 Nonmetallic-sheathed wiring (NJ Ex Order 26) was not protected in interior walls or in conduit in the dry sprinkler room. - The facility was inspected to ensure that there is no other unprotected nonmetallic-sheathed wiring (NJ Ex Order 26.4) in the facility. - All patients have the potential to be affected. - Nonmetallic-sheathed wiring (NJ Ex Order 26.4) was covered on 2/22/24 to ensure it is protected in the interior walls in the identified area. - Maintenance Director/Designee to perform a facility wide audit to ensure that there are no unprotected nonmetallic-sheathed wiring	

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	315265	A. BUILDING **01** B. WING _____	**02/08/2024**

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COMPLETE CARE AT GREEN ACRES	**1931 LAKEWOOD ROAD** **TOMS RIVER, NJ 08755**

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K 511	Continued From page 4	K 511	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. - See attached Pictures/proof of compliance	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315265	A. Building 01 - MAIN BUILDING 01 B. Wing	4/3/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT GREEN ACRES	1931 LAKEWOOD ROAD TOMS RIVER, NJ 08755

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ID Prefix Reg. # NFPA 101 LSC K0347	Correction Completed 03/15/2024	ID Prefix Reg. # NFPA 101 LSC K0372	Correction Completed 03/18/2024	ID Prefix Reg. # NFPA 101 LSC K0511	Correction Completed 03/18/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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
2/8/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**