

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Complete Care at Green Acres		STREET ADDRESS, CITY, STATE, ZIP CODE 1931 Lakewood Road Toms River, NJ 08755	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses that included heart failure, hypertension, and stroke. 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 06/04/25, indicated R126 had a Brief Interview of Mental Status (BIMS) score of five out of 15, which indicated R126 was severely cognitively impaired. Review of R126's Nursing Progress Notes, located under the Progress Note tab in the EMR, indicated on 07/17/25 at 2:49 PM, . During medication pass, patient noted to be lethargic, BP [blood pressure] 71/54, P [pulse] 86. Responds to verbal stimuli. Call placed to [name of medical doctor (MD)], informed of current status. Orders received . 12 PM [sic] patient seen by wound NP [nurse practitioner], patient noted with left facial droop, slow to respond. Call placed to [name of medical doctor (MD)], order received to send patient to [name of hospital] for eval [evaluation] . Review of R126's Notice of Emergency Transfer, provided by the facility and dated 07/17/25, indicated the reason for transfer was General Weakness. 2. Review of R164's undated Face Sheet, located under the Profile tab in the EMR, indicated R164 was admitted to the facility on [DATE] with diagnoses that included bilateral above the knee amputation. 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 [DATE]. Review of R164's Nursing Progress Notes, located under the Progress Note tab in the EMR, indicated on 06/08/25 at 12:40 PM, . Writer met with patient and spoke to daughter via [by] video call. [sic] regarding pain management and patient's constant complaint of pain 10/10 despite pharmacological and non-pharmacological interventions. Both expressed extreme desire to go back to the hospital as oral medications are not helping her mom's pain. [Name of MD] notified with orders to send patient out to [name of hospital] . Review of R164's New Jersey Universal Transfer Form, dated 06/08/25 and provided by the facility, indicated the reason for transfer was Unrelieved Pain - Lt [left] leg [sic]. Review of R164's Notice of Emergency Transfer, provided by the facility and dated 06/08/25, indicated the reason for transfer was for Evaluation. During an interview on 07/31/25 at 5:30 PM, the Social Services Director (SSD) 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 Administrator 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. 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 (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] with diagnoses that included unstageable pressure ulcer of the sacral region. Review of R191's admission MDS, located under the MDS tab of the EMR and with an ARD of 05/19/25, indicated R191 had a BIMS score of six out of 15, which indicated R191 was severely cognitively impaired. There was no documentation of the unstageable pressure ulcer to the sacral region on this form. Review of R191's Nursing Progress Notes, located under the Progress Note tab in the EMR and dated 05/20/25 at 2:16 PM, indicated, . 2nd [sic] skin check -pressure sore noted to sacrum -redness noted to bony premises on back -dryness to BLE [bilateral lower extremities [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 pressure sore. During an interview on 07/31/25 at 4:30 PM, the Director of Nursing (DON) stated, The nurse should document the description of the wound 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)NJAC 8:39-35.2		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, policy review, and review of McGeer criteria, the facility failed to have an Antibiotic Stewardship Program that followed current standards of practice for prescribing an antibiotic for one of four residents (Resident (R) 99) reviewed for antibiotic stewardship out of total sample of 32. This failure had the potential to cause residents to be prescribed antibiotics 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 [DATE] with the most recent diagnosis being heart failure. Review of R99's Nursing Progress Notes, located under the Progress Note tab in the EMR and dated 02/04/25 at 6:59 AM, indicated, . Patient stayed on w/chair [wheelchair] all night; 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 02/07/25 at 9:46 AM, indicated, . labs referred, new order to start Bactrim [an antibiotic] DS [double strength] 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 Urinalysis lab report, provided by the facility and with a collection date of 02/05/25 and a reported date of 02/07/25, revealed the urinalysis, microscopic was performed. Review of R99's Urine Culture lab report, provided by the facility and with a collection date of 02/05/25 and a reported date of 02/07/25, revealed results of the organism being Escherichia coli 50,000 to 100,000 colonies. Review of R99's untitled infection surveillance form, provided by the facility and dated 02/07/25, indicated the form was not filled out completely and the area marked was UTI criteria NOT met. During an interview on 07/31/25 at 5:30 PM, the Regional Clinical Director (RCD) and the Infection Preventionist (IP) confirmed the rationale of obtaining a urinalysis with culture and sensitivity should not have been patient staying up in her wheelchair all night even though they stated this was abnormal for the patient to do. NJAC 8:39-19.4(d)		