STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315320	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Holiday City	4 Plaza Drive Toms River, NJ 08757

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of medical records, and review of other pertinent facility documents on 5/05/2026, it was determined that the facility failed to maintain a safe environment and to provide adequate supervision to prevent the elopement of a resident (Resident #2) who was assessed to be cognitively impaired and was identified as an elopement risk.Resident #2 exited their secured unit without staff knowledge and eloped from the facility on 4/22/2026 at approximately 8:01 PM. A visitor exited the secured unit at approximately 8:00 PM on 4/22/2026 by entering a code into a keypad allowing Resident #2 to also exit the unit. Resident #2 followed the visitor to the front lobby where the receptionist enabled the front door to open which allowed Resident #2 to exit along with the visitor. The receptionist stated that they have photos of all the residents on elopement risk on the wall at reception desk area, but she did not check the residents photos because she assumed both were visitors. The resident was later found by the police approximately 1 mile away at 8:58 PM and was brought back to the facility at 9:15 PM.The facility's failure to maintain a safe environment and provide adequate supervision to prevent Resident #2 from leaving the facility without staff knowledge, placed this resident as well as all residents at risk for elopement, at risk and at the likelihood of serious harm, injury, impairment, or death. This resulted in an Immediate Jeopardy (IJ) situation.The IJ began on 04/22/2026 at approximately 8:00PM, after Resident #2 exited the facility without staff knowledge. The Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing (DON) were informed of the F689 IJ and were provided with the IJ template on 05/05/2026 4:31 P.M.The IJ was Past Non-Compliance (PNC). This deficient practice was identified for 1 of 3 residents (Resident #2) reviewed for elopement. A review of the facility's policy titled: Elopement and wandering Residents with an implementation date of 9/1/2024, Under Policy revealed: This facility ensures that residents who exhibit wandering behavior and/or at risk for elopement receive adequate supervision to prevent accidents, and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk. Under Policy Explanation and Compliance Guidelines: 4d. Adequate supervision will be provided to help prevent accidents or elopement. A review of the Facility's Reportable Event (FRE) with an event date of 4/22/2026, which the facility submitted to the New Jersey Department of Health (NJDOH), revealed that at approximately 9:00 PM on 4/22/2026, the facility received a call from the police patrol officer who informed the facility that their resident was outside. The FRE stated that Resident #2 was then escorted to their unit, and that staff assessed the resident and found no abnormalities. According to the police report dated 4/22/2026, at 8:58 PM, the police department was notified by a dispatched emergency call which indicated that they observed an elderly person on the street who appeared disoriented. The police report stated that officers went to the location (approximately 1mile away from the facility) and found the resident. The police stated that the resident could not state what city their home is located and was unsure where they lived. The police retrieved an identification card from the resident which helped locate and contact the resident's family member. The resident's family member then informed the police of the resident lived at the (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	nursing facility. The police returned the resident to the facility on 4/22/26 at 9:15 PM According to the admission Record face sheet, Resident #2 was admitted to the facility with diagnoses which included but were not limited to: metabolic encephalopathy (a brain dysfunction caused by systematic illness, organ failure), chronic obstructive pulmonary disease (a progressive, treatable lung disease) and acute kidney failure (a sudden often reversible decline in kidney).According to the quarterly Minimum Data Set (MDS), an assessment tool dated 4/19/2026, Resident #2 had a BIMs score of 5 out of 15, which indicated the resident's cognition was severely impaired. A review of Resident #2's Elopement assessment dated [DATE] at 3:42 PM, indicated that Resident #2 was a risk for elopement. The elopement evaluation stated that Resident #2 answered Yes to the question: has the resident expressed the desire to leave, go home talked about going on a trip, or attempted to pack belongings. The evaluation under behavior, stated that Resident #2 displayed shadowing of staff or residents and hovering at exits.A review of Resident #2's Care Plan (CP) initiated on 4/17/2026, with revision date of 4/28/2026, included that Resident #2 has a history of attempts to leave the facility and may try to leave the building without supervision related to impaired safety awareness, and that the resident wanders aimlessly. The CP included an intervention to make sure all staff are aware of elopement risk. An interview was conducted on 5/05/2026 at 12:53 PM with the Receptionist who stated he worked at the front desk on 4/22/2026 from 3:00 P.M to 8:00 P.M. The receptionist stated that he observed Resident #2 standing with a visitor as the visitor signed out at the kiosk around 8:00 PM on 4/22/2026. He stated that after the visitor signed out, both visitor and Resident #2 walked out of the building. He stated that he assumed they were together, and so, he did not ask them to sign out individually. The Receptionist confirmed that the pictures of residents at risk for elopement were at the front desk, but he did not look at the pictures or question Resident #2. The receptionist further stated that after the elopement on 4/22/2026, they were provided an in-service training on not sharing the exit code with anyone who was not an employee of the facility.The surveyor observed the reception desk area and noted that Resident #2's photo was on the wall next to the receptionist's desk along with other residents' photos.An interview was conducted on 05/05/2026 at 12:09 PM with the LNHA in the presence of the DON. The LNHA stated that visitors should not have access to the code for a secured unit. She stated that the receptionist should have asked about the person standing near the visitor (Resident #2) when the visitor signed out. A review facility's document titled: Investigative Summary and Conclusion (ISC), revealed that Resident #2 followed a family member who was visiting on the secured unit and exited the unit. The ISC stated that the family member visited the facility daily and so, had access to the locked unit's exit door keypad code; and that he used the code to open the unit door on the locked unit without asking staff. The ISC further stated that Resident #2 then followed the visitor down to the front lobby and left the facility by following the visitor. The ISC stated that it was the police officer that called to let the facility know the found the resident in the community near the facility.An acceptable Removal Plan (RP) was received on 5/06/2026 at 2:03 PM, indicating the action the facility would take to prevent serious harm from occurring or reoccurring. The facility implemented a corrective action plan to remediate the deficient practice, including: Head count immediately completed at 9:00 P.M by the nursing supervisor with all residents accounted for. Resident #2 was assessed at the time of the incident on 4/22/2026 by nursing supervisor at 9:20 P.M.Head to toe assessment and pain assessment completed with no new findings noted. Resident #2 was placed on 1:1 supervision pending psychiatric review. All doors and windows evaluated for proper function by maintenance Director and Regional administrator on04/22/2026, with no concerns identified. All facility residents reassessed by unit mangers/nursing supervisors for elopement risk on 4/23/2026. Elopement binders reviewed/updated by unit managers and Director of Nursing on each unit and front desk on 4/23/2026. Receptionists were reeducated on 4/23/2026 by the Director of Nursing and designees on Wandering Residents and Elopement, the Elopement Binder, and protocols for allowing visitors out of the facility. Specifically, regarding not allowing visitors to leave without all parties checking out. In-service initiated with all staff on (continued on next page)

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