STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90119	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 000	Initials Comments TYPE OF SURVEY: Complaint COMPLAINT #: NJ00185636, NJ00173530, NJ00162905 CENSUS: 74 SAMPLE SIZE: 4 SURVEY DATE: 10/28/2025 - 10/29/2025 The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:43, General Licensure Procedures and Standards Applicable to All Licensed, based on this Complaint Survey. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	H 000		
H4240	8:43E-11.11(a) VIOLECE:INCIDENT RESPNSE INVSTIGATN&REPORTNG A covered facility shall respond to violent acts, conduct incident investigations and prepare incident investigation reports in keeping with procedures specified by the violence prevention committee. This REQUIREMENT is not met as evidenced by: Based on facility policy review, record review, facility document review, and interview, the facility failed to complete a thorough investigation for 1	H4240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90119	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H4240	Continued From page 1	H4240		

of 2 reports of NJ Exec Order reviewed. Specifically, Resident #4 stated that they were NJ Exec Order 26.4b1 when they resided on the NJ Exec Order 26.4b1 unit, and the facility failed to perform NJ Exec O audits on the other NJ Exec Order 26.4b1 residents on the unit to ensure additional NJ Exec Order had not occurred.

Findings included:

An undated facility policy titled, "Abuse Prevention" indicated, "The Community ' s goal is to prevent physical abuse, neglect, abandonment, intimidation, cruel punishment, fiduciary abuse or other treatment with resulting physical harm, pain, or mental suffering or the deprivation by a care custodian of goods or services which are necessary to avoid physical harm or mental suffering."

Resident #4's "Face Sheet" indicated the facility admitted the resident on NJ Exec Order 26.4b1. The Face Sheet indicated the resident had a medical history that included a diagnosis of NJ Exec Order 26.4b1

Resident #4's "General Service Plan," dated NJ Exec Order 26.4b1, indicated the resident had diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 Per the General Service Plan, the resident was NJ Exec Order 26.4b1.

A facility "Reportable Event Record/Report," dated NJ Exec Order 26.4b1, indicated that a NJ Exec Order 26.4b1 was made on NJ Exec Order 26.4b1 at 7:30 PM involving Resident #4.

A typed facility document titled, "Reportable Event NJ Exec Order -Narrative" indicated that, while being admitted to a new facility on NJ Exec Order 26.4b1 Resident #4, who had resided on the NJ Exec Order 26.4b1 at this facility, stated that they had been NJ Exec Order 26.4 at this facility. Per the document,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90119	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H4240	Continued From page 2	H4240		

when NJ Exec Order arrived, the resident ' s Power of Attorney told them that a that a staff member had NJ Exec Order 26.4b1 Resident #4. Per the report, the resident ' s description of the staff member matched that of Certified Nursing Assistant (CNA) #1. The report indicated that CNA #1 was immediately NJ Exec Order 26.4b1 pending an investigation.

The investigation documents revealed that Resident #4 ' s new facility sent the resident to the hospital for evaluation as a precaution, but there were no findings indicating any NJ Exec Order 2 had occurred. The documents revealed that NJ Exec Order arrived at the facility and spoke with the Executive Director (ED) regarding the incident but did not pursue NJ Exec Order 26.4b1. The facility ' s investigation included interviewing staff who routinely worked with CNA #1, an NJ Exec Order and NJ Exec Order 26 in-service with all staff, and a NJ Exec Order 26.4b1 for CNA #1 with no substantial findings. The facility did not substantiate the NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1.

The investigation documents did not, however, include NJ Exec O audits of the other NJ Exec Order 26.4b1 residents who resided on the NJ Exec Order 26.4 unit, who would have had contact with CNA #1, or interviews with any residents who had the NJ Exec Order 26.4b1 if they NJ Exec Order 26.4 in the facility.

During an interview on 10/29/2025 at 3:08 PM, the Executive Director (ED) stated the investigation did not include NJ Exec O audits of the other residents who resided on the NJ Exec Order 26.4b1 unit. The ED further stated he expected staff to immediately report any changes to a resident ' s NJ Exec O so they could determine what may have occurred.

During an interview on 10/29/2025 at 4:12 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90119	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H4240	Continued From page 3 the Director of Nursing (DON) stated she expected [NJ Exec O] checks to be completed on all the residents on the [NJ Exec Order 26.4b1] unit during the facility investigation.	H4240		
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Complaint COMPLAINT #: NJ00185636, NJ00173530, NJ00162905 CENSUS: 74 SAMPLE SIZE: 4 SURVEY DATE: 10/28/2025 - 10/29/2025 The facility is not in substantial compliance with all the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs, based on this Complaint Survey. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90119	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 4	A 310		

This REQUIREMENT is not met as evidenced by:
Based on facility policy review, record review, facility document review, and interview, the facility failed to ensure staff implemented their policy related to [redacted] management, which affected 1 (Resident #1) of 3 residents reviewed for quality of care. Specifically, the facility failed to thoroughly complete documents that the facility used to analyze [redacted] following each of Resident #1's [redacted]

Findings included:

An undated facility policy titled, "Protocol for Falls Management" indicated, "The purpose of the falls management protocol is to identify causes of falls and intervene appropriately with a goal of reducing resident falls and the potential for injury." The policy revealed, "2. Interventions to prevent falls shall be noted on the General Service Plan." The policy revealed, "3. An Incident Report shall be generated for each fall and shall include as much detail as possible surrounding the events causing the resident to fall." The policy continued, "4. The Incident Report shall be reviewed by the Wellness Director who will consult, as appropriate, with personnel, the resident, family, physician,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90119	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 5	A 310		

therapists or other individuals who may be able to assist with designing interventions to reduce future falls. 'When a fall occurs while an R.N. [registered nurse] is in the building, the R.N. will promptly assess the resident. When a fall occurs when an R.N. is not in the building, the ranking clinical staff member will contact the R.N. on call via phone, who may triage the resident to determine if transfer to hospital for evaluation is necessary. If no transfer indicated, R.N. will assess resident upon next presence in the facility.' The assessment will be documented in the Nurses Notes and any needed adjustment in the service plan completed as soon as dictated by the circumstances of the fall." The policy revealed, "7. A post fall assessment tool may be utilized to further identify causes and possible additional interventions necessary for fall prevention."

Resident #1's "Face Sheet" indicated the facility admitted the resident on NJ Exec Order 26.4b1. The Face Sheet revealed Resident #1 had a medical history that included a diagnosis of NJ Exec Order 26.4b1

Resident #1's "General Service Plan," revised NJ Exec Order 26.4b1, indicated the resident had diagnoses of NJ Exec Order 26.4b1. The General Service Plan indicated the resident was at risk for NJ Exec Or had NJ Exec Order 26.4b1 required NJ Exec Order 26.4b1 with NJ Exec Order 26.4 and NJ Exec Order 26.4b1 and utilized a wheelchair, NJ Exec Order 26.4b1, or NJ Exec Order assistance for NJ Exec Order 26.4b1

A facility "Incident/Accident Report," dated NJ Exec Order 26.4b1, indicated staff found Resident #1 on the floor, with NJ Exec Order 26.4b1 noted.

A 'NJ Exec' Investigation Checklist," dated NJ Exec Order 26.4b1, revealed "Section I (to be completed by employee

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90119	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 6	A 310		

that found incident)," "Were any of the following indicated at the time of the incident/resident found?" Section I of the report indicated Resident #1 was in a hurry at the time of the [NJ Exec] "Section II (to be completed by RN)" included the following questions:
- "Have any of the following changes occurred in the resident's [NJ Exec Order 26.4b1]
- "How many [NJ Exec O] has the resident had this month?"
- "Is the resident high risk for [NJ Exec Order]
- "If Yes, is this indicated on the General Service Plan?"
The [NJ Exec] Investigation Checklist revealed that each question for Section II was left blank.

A facility "Incident/Accident Report," dated [NJ Exec Order 26.4b1], indicated staff went to administer medications to Resident #1 and [NJ Exec Orde] the resident on the [NJ Exec Orc] The report indicated that the resident stated that they NJ Exec Order 26.4b1 ."

A "[NJ Exec] Investigation Checklist," dated [NJ Exec Order 26.4b1], revealed, "Section I (to be completed by employee that found incident)," "Were any of the following indicated at the time of the incident/resident found?" Section I of the report was blank. "Section II (to be completed by RN)" included the following questions:
- "Have any of the following changes occurred in the resident's [NJ Exec Order 26.4b1]
- "How many [NJ Exec O] has the resident had this month?"
- "Is the resident high risk for [NJ Exec Order]
- "If Yes, is this indicated on the General Service Plan?"
The [NJ Exec] Investigation Checklist revealed that each question for Section II was left blank.

During an interview on 10/29/2025 at 4:12 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90119	A. BUILDING: _____ B. WING _____	C 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 310	Continued From page 7 the Director of Nursing (DON) stated Resident #1's incident reports following their [NJ Exec C] should have been completed more thoroughly with what the resident was doing at the time of the [NJ Exec] and new interventions implemented to prevent further [NJ Exec Or] During an interview on 10/29/2025 at 3:08 PM, the Executive Director (ED) stated that [NJ Exe] investigations included what the resident was doing at the time of the [NJ Exe] and stated that interventions were implemented based on the individualized event. The ED further stated there should have been more documentation on Resident #1's incident reports to include a root cause analysis.	A 310		

POC # 3 Received 1/21/26
Acceptable

Plan of Correction for Complete Care at Arbors Haven
Complaint Survey Completed on 10/29/25

H4240

1. Resident #4 is no longer a resident at Complete Care at Arbors Haven 2. All residents have the potential to be affected. 3. On January 5th, immediately following notification of the deficiency, the Administrator reviewed the New Jersey State Regulations 8:43-11.11(a) and reviewed the facility protocol titled, Abuse Prevention, with the Director of Nursing/Registered Nurse and Assistant Director of Nursing. Additionally, an in-service was completed with all staff on December 16th, 2025 titled, Abuse Prevention and Reporting. 4. To ensure that the deficient practice will not recur, an investigation checklist will be developed to follow any reported abuse including skin audits. This investigation checklist will be signed off by the Director of Nursing/Registered Nurse and Administrator. An in-service will be scheduled every 6 months on reporting potential resident abuse with all staff. The Administrator and Director of Nursing/Registered Nurse will be responsible for continued compliance. The Deficient Practice was corrected by December 16th, 2025.

Accepted

A310

1. Resident #1 is no longer a resident at Complete Care at Arbors Haven. 2. All residents have the potential to be affected. 3. On January 5th, immediately following notification of the deficiency, the administrator reviewed the New Jersey State Regulations (8:36-3.4(a)(1) and reviewed the facility protocol titled, "Protocol for Falls Management" with the Director of Nursing/Registered Nurse and Assistant Director of Nursing. On January 5th, a training program was developed for all new hires providing resident care that is overseen by the Director of Nursing Registered Nurse. This includes fall prevention, reporting procedures, and documentation of falls/incident reports. 4. To ensure that the deficient practice will not recur, a fall prevention/incident report orientation checklist will be signed off by the Director of Nursing/Registered Nurse for each staff member that provides resident care upon completion. This checklist will be in each employee file. To monitor the continued effectiveness, a quarterly Quality Assurance will be completed on 10% of the nursing roster until substantial compliance is achieved by March 15th, 2026. The Administrator and Director of Nursing/Registered Nurse will be responsible for continued compliance. The Deficient Practice was corrected by January 5th, 2026.

NJ Exec Order 26.4b1 1/21/26

Accepted

Executive Director

Complete Care at Arbors Haven
1730 Route 37 West
Toms River, NJ 08757

NJ Exec Order 26.4b1

NJ Exec Order 26.4b1

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
90119 (Y1)	A. Building B. Wing (Y2)	1/21/2026 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 H4240 Reg. # 8:43E-11.11(a) LSC	Correction Completed 12/16/2025	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
10/29/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
90119	A. Building B. Wing	1/21/2026

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 H4240 Reg. # 8:43E-11.11(a) LSC	Correction Completed 12/16/2025	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 10/29/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: 0GK612

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
90119 (Y1)	A. Building B. Wing (Y2)	1/21/2026 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 01/05/2026	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	
10/29/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
90119 Y1	A. Building B. Wing Y2	1/21/2026 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS HAVEN	1700 ROUTE 37 WEST TOMS RIVER, NJ 08757

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 01/05/2026	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	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

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	
10/29/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO