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 07/24/2021

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 000	Initial Comments Initial Comments: TYPE OF SURVEY: COVID-19 Focused Infection Control COMPLAINT #: NJ00147002 CENSUS: 77 SAMPLE SIZE: 3 A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 07/24/2021. The facility was found to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		

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