New Jersey Department of Health

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 09/18/2023

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: SURVEY TYPE: Complaint COMPLAINT #: NJ00167140, NJ00152852, NJ00152754 CENSUS: 75 SAMPLE SIZE: 3 The facility is in substantial compliance with N.J.A.C. Title 8 Chapter 36- Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs for this Complaint Investigation.	A 000		

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