

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 50A006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/19/2025
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT WHISPERING WOODS LI	STREET ADDRESS, CITY, STATE, ZIP CODE 62 JAMES STREET EDISON, NJ 08820
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(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	<p>Initial Comments</p> <p>Initial Comments: Type of Survey: Complaint</p> <p>Complaint #: NJ 00186160</p> <p>Census: 68</p> <p>Sample: 3</p> <p>The facility is not in substantial compliance with all of 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. 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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administrator's Responsibilities</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p>	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/11/25

New Jersey Department of Health

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A 310	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00186160</p> <p>Based on interview and record review, it was determined that the Administrator failed to ensure that the facility policy titled, "Elopement/ Missing Residents Policy and Procedure", was implemented and enforced related to the [redacted] of 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 5/19/25 at 10:30 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that Resident #2 moved into the facility in [redacted], with diagnoses of [redacted] and [redacted].</p> <p>Additionally, the surveyor reviewed an [redacted] completed by the Director of Nursing (DON) dated [redacted] which indicated that Resident #2 had a history of [redacted] prior to admission to the facility, from a [redacted] in [redacted] of [redacted]. The [redacted] also indicated that as per the family, Resident #2 had a history of [redacted].</p> <p>The surveyor reviewed a "LATE ENTRY" progress note (PN) dated [redacted] at 2:25 p.m., written by a Licensed Practical Nurse (LPN), which revealed, "At around 12:00 PM, aide informed nurse that resident [redacted] [his/her] [redacted] A [redacted] of the unit and the surrounding area was conducted. The resident</p>	A 310		

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A 310	<p>Continued From page 2</p> <p>was [redacted] by staff at around 10:45 AM, going into [his/her] room. The resident was determined to have [redacted] without authorization or staff knowledge ... Resident was [redacted] at approximately 12:30 PM and [redacted] to the facility by around 12:35 p.m. ..."</p> <p>At 10:30 a.m., the surveyor interviewed the Assistant Director of Nursing (ADON), a LPN. The surveyor inquired about Resident #2's [redacted] on [redacted], and if the ADON was aware that the resident was an [redacted] risk. The ADON stated that she did not know Resident #2's history and that it was the Registered Nurse (RN) who assessed the residents before they moved in, determined the resident's history, and [redacted] risk.</p> <p>During continued interview, the surveyor inquired about who completed the Service Plans (SP), and how often was the SP updated for the residents. The ADON stated that she assisted the RN to complete the SPs and that she was not sure how often the SPs were updated since they were only updated by the RN.</p> <p>At 12:30 p.m., the surveyor reviewed Resident #2's SP dated [redacted], on admission, however, the surveyor did not observe documentation to reflect the resident's prior history of [redacted] on admission to the facility. The surveyor also observed a revision to the SP dated [redacted], after the resident's [redacted]. However, the SP did not include documentation of the actual [redacted] on [redacted] when the resident [redacted] the facility unaware by facility staff.</p> <p>At 1:20 p.m., the surveyor interviewed the Executive Director (ED) and inquired about</p>	A 310		

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A 310	<p>Continued From page 3</p> <p>Resident #2's [redacted] on [redacted]. The ED stated that although an investigation was completed, she was unsure how Resident #2 [redacted] and [redacted] and [redacted] into the [redacted]. The ED stated that it might have been a family member [redacted], not realizing the resident resided in the [redacted]. The ED explained that a code was not required to enter the unit. The surveyor asked if there was a [redacted] in place and the ED stated that the facility did not utilize a [redacted].</p> <p>During continued interview, the surveyor inquired about how the staff learned about new admissions in the [redacted] and if there were photos of residents kept at the front desk. The ED explained that there was an email blast which was sent out to all the facility staff when there was a new admission. The ED informed the surveyor that they only placed a photo of a resident at the front desk if they [redacted] and explained that Resident #2's [redacted] was placed at the [redacted] and at the nursing stations after the [redacted] on [redacted].</p> <p>The surveyor reviewed a facility policy, dated 9/2018, with a revision date of 12/31/23 titled, "Elopement/ Missing Residents Policy and Procedure", which revealed the following: "Policy It is always the policy of the facility to protect residents by identifying and preventing the possibility of elopement and locating residents who are reported missing."</p> <p>"Procedure Prevention 1). Upon admission, and on an ongoing basis, nursing will identify any resident who is an elopement risk. Elopement risk will be assessed and identified by, but not limited to the following: ... any history of elopements</p>	A 310		
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A 310	Continued From page 4 from home, hospital and/or other facilities ... 2). The IDCP team will be informed of any resident identified as risk and a care plan will be implemented ... 4). In addition, residents who are determined to be an immediate risk for elopement will be placed on a wander guard monitoring system when applicable. 5). A care plan will be developed to address elopement/wandering risk ... 9). Photo of resident who at elopement risk will be kept at the reception area and on each unit ..."	A 310		
A 401	8:36-4.1(a)(22) Resident Rights (a) Each assisted living provider shall post and distribute a statement of resident rights for all residents of assisted living residences, comprehensive personal care homes, and assisted living programs. Each resident is entitled to the following rights: 22. The right to live in safe and clean conditions in a facility that does not admit more residents than it can safely accommodate while providing services and care; This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00186160	A 401		

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A 401	<p>Continued From page 5</p> <p>Based on observation, interview and record review, it was determined that the facility failed to ensure a safe environment for a resident who eloped from a NJ Exec Order 26.4b1 unit, for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>The Department of Health (DOH) received a Facility Reportable Event (FRE) (a document used to report events to the DOH) dated NJ Exec Order 26.4b1, regarding the NJ Exec Order 26.4b1 of a resident from a NJ Exec Order 26.4b1 which occurred on NJ Exec Order 26.4b1. According to the FRE, Resident #2 was NJ Exec Order 26.4b1 at approximately 11:00 a.m. in the NJ Exec Order 26.4b1 and "a little before" noon, the staff noticed that Resident #2 was NJ Exec Order 26.4b1. The FRE further revealed that Resident #2 was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 to the facility at around 12:30" noon.</p> <p>On 5/19/25 at 10:30 a.m., the surveyor investigated and reviewed Resident #2's medical record (MR) which revealed that Resident #2 moved into the facility in NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 with diagnoses of NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The surveyor observed Resident #2 in the NJ Exec Order 26.4b1 sitting in a chair watching television in a common area. The surveyor was NJ Exec Order 26.4b1 the resident due to NJ Exec Order 26.4b1.</p> <p>Additionally, the surveyor reviewed an NJ Exec Order 26.4b1 completed by the Director of Nursing (DON) dated NJ Exec Order 26.4b1, which indicated that Resident #2 had a history of a prior NJ Exec Order 26.4b1 before admission to the facility, from a NJ Exec Order 26.4b1 in NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 also indicated that as per the family, Resident #2 had a history of NJ Exec Order 26.4b1.</p> <p>The surveyor reviewed a "LATE ENTRY"</p>	A 401		

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A 401	<p>Continued From page 6</p> <p>progress note (PN) dated [redacted] at 2:25 p.m., written by a Licensed Practical Nurse (LPN), which revealed, "At around 12:00 PM, aide informed nurse that resident [redacted] [his/her] [redacted] A [redacted] of the unit and the surrounding area was conducted. The resident was [redacted] by staff at around 10:45 AM, going into [his/her] room. The resident was determined to have [redacted] without authorization or staff knowledge ... Resident was [redacted] at approximately 12:30 PM and [redacted] to the facility by around 12:35 p.m. ..."</p> <p>At 10:30 a.m., the surveyor interviewed the Assistant Director of Nursing (ADON), a LPN. The surveyor inquired about Resident #2's [redacted] or [redacted] and if the ADON was aware that the resident was an [redacted]. The ADON stated that she did not know Resident #2's history and that it was the Registered Nurse (RN) who assessed the residents before they moved in, determined the resident's history and [redacted].</p> <p>Additionally, the ADON informed the surveyor that she knew Resident #2 was [redacted] and [redacted], but was unsure if the facility knew [redacted]. The ADON explained that she could not remember if she was working that day and therefore, could not provide further details regarding the [redacted]. During continued interview, the surveyor inquired about who completed and how often was the Service Plans (SP) updated for the residents. The ADON stated that she assisted the RN to complete the SPs and that she was not sure how often the SPs were updated since they were only updated by the RN.</p> <p>At 11:00 a.m., the surveyor reviewed the facility</p>	A 401		

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A 401	<p>Continued From page 7</p> <p>investigation summary which included written statements from the staff. The surveyor reviewed a statement from a recreation staff member who was also identified by the Executive Director (ED) as a facility bus driver (BD). The statement revealed that on [redacted] at approximately 12:15 p.m., the BD was informed that a resident from the [redacted] from the facility. The statement further revealed that the BD then recalled an earlier interaction at approximately 11:00 a.m., with an [redacted] who asked for [redacted] to the [redacted].</p> <p>The BD gave the individual [redacted] to the [redacted] and was unaware at that time, that the individual was the resident from the [redacted] who [redacted].</p> <p>At 1:20 p.m., the surveyor interviewed the ED and inquired about Resident #2's [redacted] on [redacted]. The ED stated that although an investigation was completed, she was unsure how Resident #2 [redacted] and [redacted] into the [redacted]. The ED stated that it might have been a family member who [redacted] not realizing the resident resided in the [redacted]. The ED explained that a code was not required to enter the unit. The surveyor asked if there was a [redacted] in place and the ED stated that the facility did not utilize a [redacted].</p> <p>During continued interview, the surveyor inquired about how the staff learned about new admissions in the [redacted] and if there were photos of residents kept at the front desk. The ED explained that there was an email blast which was sent out to all the facility staff when there was a new admission. The ED informed the surveyor that they only placed a photo of a resident at the front desk if they [redacted] and [redacted].</p>	A 401		

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A 401	<p>Continued From page 8</p> <p>explained that Resident #2's ^{NJ Exec Order} was placed at the ^{NJ Exec Order 26.4b1} and at the nursing stations after the ^{NJ Exec Order 26.4b1}.</p> <p>The surveyor reviewed a facility policy, dated 9/2018, with a revision date of 12/31/23 titled, "Elopement/ Missing Residents Policy and Procedure", which revealed the following: "Policy It is always the policy of the facility to protect residents by identifying and preventing the possibility of elopement and locating residents who are reported missing."</p> <p>"Procedure Prevention 1). Upon admission, and on an ongoing basis, nursing will identify any resident who is an elopement risk. Elopement risk will be assessed and identified by, but not limited to the following: ... any history of elopements from home, hospital and/or other facilities ... 2). The IDCP team will be informed of any resident identified as risk and a care plan will be implemented ... 4). In addition, residents who are determined to be an immediate risk for elopement will be placed on a wander guard monitoring system when applicable. 5). A care plan will be developed to address elopement/wandering risk ... 9). Photo of resident who at elopement risk will be kept at the reception area and on each unit ..."</p>	A 401		
A 749	<p>8:36-7.3(a) General and Health Service Plans</p> <p>(a) The resident general service plan shall be reviewed and, if necessary, revised semi-annually, and more frequently as needed based upon the resident's response to the care provided and any changes in the resident's physical or cognitive status.</p>	A 749		

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A 749	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #: NJ 00186160</p> <p>Based on interview and record review, it was determined that the facility failed to ensure that the General Service Plan was updated to reflect a history of [redacted] for 1 of 3 residents reviewed, Resident #2. This deficient practice was evidenced by the following:</p> <p>On 5/19/25 at 10:30 a.m., the surveyor reviewed Resident #2's medical record (MR) which revealed that Resident #2 moved into the facility in [redacted] of [redacted] with diagnoses of [redacted] and [redacted].</p> <p>Additionally, the surveyor reviewed an [redacted] completed by the Director of Nursing (DON) dated [redacted], which indicated that Resident #2 had a history of [redacted] prior to admission to the facility, from a [redacted] in [redacted] of [redacted]. The [redacted] also indicated that as per the family, Resident #2 had a history of [redacted].</p> <p>The surveyor reviewed a "LATE ENTRY" progress note (PN) dated [redacted] at 2:25 p.m., written by a Licensed Practical Nurse (LPN), which revealed, "At around 12:00 PM, aide informed nurse that resident [redacted] [his/her] [redacted]. A [redacted] of the unit and the surrounding area was conducted. The resident</p>	A 749		

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A 749	<p>Continued From page 10</p> <p>was [redacted] by staff at around 10:45 AM, going into [his/her] room. The resident was determined to have [redacted] without authorization or staff knowledge ... Resident was [redacted] at approximately 12:30 PM and [redacted] to the facility by around 12:35 p.m. ..."</p> <p>At 10:30 a.m., the surveyor interviewed the Assistant Director of Nursing (ADON), a LPN. The surveyor inquired about Resident #2's [redacted] on [redacted], and if the ADON was aware that the resident was an [redacted]. The ADON stated that she did not know Resident #2's history and that it was the Registered Nurse (RN) who assessed the residents before they moved in, determined the resident's history and [redacted].</p> <p>During continued interview, the surveyor inquired about who completed Service Plans (SP) and how often was the SP updated for the residents. The ADON stated that she assisted the RN to complete the SPs and that she was not sure how often the SPs were updated since they were only updated by the RN.</p> <p>At 12:30 p.m., the surveyor reviewed Resident #2's SP dated [redacted], on admission, however, the surveyor did not observe documentation to reflect the resident's prior history of [redacted] on admission to the facility. The surveyor also observed a revision to the SP dated [redacted], after the resident's [redacted]. However, the SP did not include documentation of the actual [redacted] on [redacted] when the resident [redacted] the facility unaware by facility staff.</p> <p>The surveyor reviewed a facility policy, dated 9/2018, with a revision date of 12/31/23 titled, "Elopement/ Missing Residents Policy and</p>	A 749		

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A 749	<p>Continued From page 11</p> <p>Procedure", which revealed the following: "... any history of elopements from home, hospital and/or other facilities ... 2). The IDCP team will be informed of any resident identified as risk and a care plan will be implemented ... 4). In addition, residents who are determined to be an immediate risk for elopement will be placed on a wander guard monitoring system when applicable. 5). A care plan will be developed to address elopement/wandering risk ... 9). Photo of resident who at elopement risk will be kept at the reception area and on each unit..."</p> <p>Refer to 8:36-4.1(a)(22)</p>	A 749		

POC # 2 Accepted
7/25/25



62 James Street

Edison NJ 08820

Tel 732-744-5541

info @ ccwhisperingwoods.com

PLAN OF CORRECTION

8:36-3.4(a) (1)

A 310

Administrator's Responsibilities

1. Problem identified:

How the corrective action/ actions will be accomplished for those residents found to be affected by the practice:

When a new Resident is admitted into the Whispering Woods memory care unit, the service plan and elopement risk will be done the same day as admission by the DON and ADON. If any updates are needed to the service plan it will be done on the same day, the updates in service and care are needed by the DON or designee. Staff will be made aware of a new admission into memory care with an email sent to all department heads with a brief description about the resident, the Resident's care needs, and a picture of the Resident. Should a Resident be an elopement risk, a picture will be printed and placed at the front desk and posted by the DON or designee in a discreet place by each department. For example, inside the kitchen, and employee break room. The policy and procedure have been updated to reflect this change, and



COMPLETECARE
WHISPERING WOODS

due to the facility not having a wander guard system it has been removed from the policy and procedure. Resident #2 was transferred to a [redacted] NJ Exec Order 26.4b1 [redacted] is a more appropriate facility equipped to accommodate [redacted] NJ Exec Order 26.4b1 [redacted] or [redacted] NJ Exec Order 26.4b1 [redacted] in conjunction with [redacted] NJ Exec [redacted] family.

2. How the facility will identify other residents having the potential to be affected by the deficient practice:

A review of all the Residents in memory care was conducted by the DON in May 2025 to ensure the updated policy and procedure was followed.

3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur?

When a new Resident is admitted into the Whispering Woods memory care unit, the service plan and elopement risk will be done the same day as admission by the DON and ADON. If any updates are needed to the service plan it will be done on the same day, the updates in service and care are needed by the DON or designee. Staff will be made aware of a new admission into memory care with an email sent to all department heads with a brief description about the resident, the Resident's care needs, and a picture of the Resident. Should a Resident be an elopement risk, a picture will be printed and placed at the front desk and posted by the DON or designee in a discreet place by each department. For example, inside the kitchen, and employee break room. The policy and procedure have been updated to reflect this change, and due to the facility not having a wander guard system it has been removed from the policy and procedure. Resident #2 was transferred to a [redacted] NJ Exec Order 26.4b1 [redacted]



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Center which is a more appropriate facility equipped to accommodate NJ Exec Order 26.4b1
NJ Exec Order 26.4b1 on NJ Exec Order 26.4b1 conjunction with NJ Exec family.

After every admission is conducted the Administrator will review the Resident chart with the DON to ensure all required documentation has been completed correctly. The Administrator will make sure all departments have been notified of the new admission with a brief description of the Resident. For elopement risks a picture will be disseminated to the front desk by the Administrator, DON or designee and other discreet areas of the facility where only staff have access.

The DON will assess for elopement risk and service plan and then it will be reviewed by the Administrator and the Nursing team making sure that all elopement policies are in place to avoid an occurrence.

The entire staff in all departments were educated on elopement / missing resident risk and prevention on 5/20/25. The education was conducted by the Administrator.

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? What program will be put into place to monitor the continued effectiveness of the systemic changes?

Cameras were placed in strategic areas by the memory care unit. Signs were posted by entrance doors to the memory care unit reminding staff and visitors to always keep the doors closed and make sure no Resident follows someone out of the unit. The Administrator will enforce the policies and procedures and will continuously monitor every new admission process.

All exit door alarm systems are checked on a weekly basis as per our facility policy and procedure By the Director of Maintenance for its functional status.



Completion Date: 7/15/25

8:36-4.1(a)(22) Resident Rights

A 401

Resident Rights

Problem identified:

1. How the corrective action/ actions will be accomplished for those residents found to be affected by the practice:

Every potential Resident will be screened prior to admittance to Whispering Woods. A screening will be conducted by the Director of Outreach and the Director of Nursing to review if the facility can take care of the Resident's needs. Upon acceptance to the facility a review of the Residents care needs will be reviewed with all the administrative staff prior to the Residents move in date. Staff will be made aware of a new admission into memory care with an email sent to all department heads with a brief description about the resident, the Resident's care needs, and a picture of the Resident. Should a Resident be an elopement risk, a picture will be printed and placed by DON or designee at the front desk and posted in a discreet place by each department.

Resident #2 was transferred to a **NJ Exec Order 26.4b1** which is a more appropriate facility equipped to accommodate **NJ Exec Order 26.4b1** or **NJ Exec Order 26.4b1** in conjunction with **NJ Exec** family.



2. How the facility will identify other residents having the potential to be affected by the deficient practice:

All Residents have the potential to be affected if the updated policy and procedures are not followed correctly. The Administrator will enforce the policy and procedures to be followed by all staff.

3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur?

The facility Maintenance Director checked all the systems in the memory care unit, and they are functioning properly. A weekly check of the systems will be conducted by Maintenance to ensure everything is in working order. Cameras were placed in strategic exit points from the memory care unit. They are in full working order.

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? What program will be put into place to monitor the continued effectiveness of the systemic changes?

The Administrator will review every potential admission with the Director of Outreach and the Director of Nursing. The facility will make sure that every Resident that is admitted is cared for and all Resident Rights enforced.

Completion Date: 7/15/25



8:36-7.3(a)

A 749

General and Health Service Plans

1. Problem identified:

How the corrective action/ actions will be accomplished for those residents found to be affected by the practice:

Upon the admission of a new Resident the general service plan will be made on the same day as the admission by the DON. The Director of Nursing and the Administrator will then revise the assessment together making sure all elements are in place as per facility policy and making sure the resident is safe.

The elopement risk assessment will also be done by the DON and then revised by the Administrator. Any adjustments to the respective service care plans will be conducted by DON and the Administrator.

Resident #2 was transferred out of the facility to a more appropriate facility that can accommodate [redacted] needs on [redacted] in conjunction with [redacted] family agreement.

2. How the facility will identify other residents having the potential to be affected by the deficient practice:

All Residents have the potential to be affected by the service plans not being done correctly and timely.



3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur?

Administrative meetings are held daily in am to review any issues in the facility. The Administrator will ensure that all service plan reports are conducted both timely and correctly. All changes in Resident's needs and behaviors will be identified during the department head meetings, and service plans will be updated accordingly by the Director of Nursing. At the end of shift a meeting is also held by all department heads to address any resolution put in place and any necessary actions needed making sure all residents remain safe in Facility.

4. How will the facility monitor its corrective actions to ensure that the deficient practice will not recur? What program will be put into place to monitor the continued effectiveness of the systemic changes?

The Administrator will revise all policies every month to make sure that they are followed by all team members. All head Departments are responsible for ongoing training and education by any employee who is working under their directive. All new employees are also trained before getting on board in a timely manner.

Completion Date: 7/15/25

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 50A006	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/1/2025
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NAME OF FACILITY COMPLETE CARE AT WHISPERING WOODS LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 62 JAMES STREET EDISON, NJ 08820
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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	Correction	ID Prefix A0401	Correction	ID Prefix A0749	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-4.1(a)(22)	Completed	Reg. # 8:36-7.3(a)	Completed
LSC	07/15/2025	LSC	07/15/2025	LSC	07/15/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/19/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 50A006	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 8/1/2025
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LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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