STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0000	INITIAL COMMENTS NJ Complaint #425698, 425699, 425693 Survey date:9/24/2025 Census:197 Sample size: 35 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		11/14/2025
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 F584 Safe/Clean/Comfortable/Homelike Environment SS-D ELEMENT ONE: CORRECTIVE ACTION: On September 23, 2025, the hole in room [NJ Ex C] was repaired ,the molding and 2 tiles in room [NJ Ex C] were repaired, the scissors and surgical tape were removed from room [NJ Ex C] shower room all non-essential shower equipment was removed and toilet paper holder repaired. Staff were educated to report any maintenance needs to the maintenance director and log in the maintenance logbook. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by this theme Safety rounds were completed by Administrator and	11/14/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0584 SS = D	Continued from page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean and sanitary environment for 2 of 3 units, the first floor second floor. This deficient practice was evidenced by the following: During initial tour on 09/18/2025 at 10:02 AM survey #1 observed the following: 1. A hole in the wall behind the door of room [redacted] 2. In room [redacted] the molding at the bottom of the wall was peeling off and there were two tiles with peeling at the edges. On 09/18/2025 at 10:24 AM during the initial tour of the facility in room [redacted] the Surveyor observed a scissors with soiled adhesive surgical tape attached to it on the windowsill. On the same date at 10:32 AM while in the shower room outside of room [redacted] the Surveyor observed geriatric recliners, a wheelchair, and mechanical lift stored in the shower room. Within the bathroom area of the shower room, the Surveyor observed a broken toilet paper	F0584	Continued from page 1 Director of maintenance and representative from the Nursing Department for all rooms , and shower rooms to ensure safe sanitary and homelike environment is maintained for all rooms in the facility . ELEMENT THREE: SYSTEMIC CHANGES: The administrator created a log for room inspection to reflect the room rounds to ensure a safe sanitary and homelike environment. The administrator educated the [redacted] and all maintenance and housekeeping staff of this requirement and log for completion of rounds daily for meeting the requirement of a safe, sanitary and homelike environment. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance, The Director of maintenance/Designee will complete log daily, and Regional Operations/designee will monitor completion of log and work needed, daily x 4weeks and weekly x 3 months to ensure log is complete and accurate. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x4 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Compliance: 11/14/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0584 SS = D	Continued from page 2 holder and toilet paper placed on top of the toilet tank. On 09/19/2025 at 9:57 AM while in room NJ Ex O the Surveyor observed the scissors with soiled adhesive surgical tape attached to it on the windowsill. 09/23/2025 at 10:59 AM during an interview with the Surveyor, the U.S. FOIA (b) (6) stated, “That should not be there” after reviewing the Surveyor’s finding of the scissors in room NJ Exec During an interview with surveyor #1 the US FOIA (b)(6) U.S. FOIA (b) (6) said there should not be peeling molding and tile, or holes in the walls of resident rooms because it’s not a homelike environment A review of a facility provided policy dated 01/04/2025 and titled "safe and Homelike environment" revealed under, " Policy Explanation and Compliance Guideline:" that, "3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. " N.J.A.C. 8:39-31.4(a)	F0584		
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by:	F0688	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 F688 Increase/prevent decrease in ROM/Mobility SS-D ELEMENT ONE: CORRECTIVE ACTION: A physician’s order for NJ Ex Order 28 for resident #80 was obtained on NJ Exec Order 2 ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents that use an orthotic have the potential to be affected. An audit was completed by therapy to ascertain residents who utilize orthotics, and to ensure MD order and care plan in place. ELEMENT THREE: SYSTEMIC CHANGES: All new admissions/re-admissions will be assessed for utilization of an orthotic and reported to Physical	11/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0688 SS = D	Continued from page 3 Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to obtain a Physician's Order (PO) for an NJ Ex Order 26.4(b)(1) for 1 of 2 residents (Resident#80) reviewed for NJ Ex Order 26.4(b)(and NJ Ex Order 26. On 09/18/2025 at 11:36 AM, the surveyor observed resident #80 in a wheelchair. An NJ Ex Order 26.4(b)(1) was observed on NJ Ex Order 26.4(b)(of Resident #80. According to the Admission Record, Resident #80 was admitted to the facility with a diagnosis including but not limited to NJ Ex Order 26.4(b)(1). Review of the Annual Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated NJ Ex Order 26.4(b)(1) reflected that the resident was NJ Ex Order 26.4(b)(1) and had NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4(b)(the NJ Exec O Review of the Order Summary Report with active orders as o NJ Ex Order 26.4(b)(1) did not reveal an order for Resident #80's NJ Ex Order 26.4(b)(1) for the NJ Ex Order 2 Review of Resident #80's current Care Plan did not reflect the use of the NJ Ex Order 26.4(b)(1) During an interview with the surveyor on 09/22/2025 at 11:13 AM, the U.S. FOIA (b) (6) stated that there should be a physician order for an NJ Ex Order 26. She acknowledged that there was no physician order for Resident #80's NJ Ex Order 26. During an interview with the surveyor on 09/24/2025 at 10:33 AM, the U.S. FOIA (b) (6) stated that there should be a physician order for an NJ Ex Order 26. The facility was unable to provide a policy regarding having a physician order for an NJ Ex Order 26. NJAC 8:39-27.1 (a)	F0688	Continued from page 3 Therapy, who will then assess resident with orthotic and confirm MD orders and initiate a care plan. Interdisciplinary team was educated by the Director of Therapy and the Assistant Director of Nursing on this process. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance, The Director of therapy/Designee will create and maintain a facility wide audit tool to monitor residents with orthotics while ensuring orders and care plans are in place. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x4 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Compliance: 11/14/25	
F0712 SS = E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.	F0712	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 F0712 Physician Visits-Frequency/Timeliness/Alt NPP SS-E	11/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0712 SS = E	Continued from page 4 §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is NOT MET as evidenced by: Complaint #425693 Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. The deficient practice was identified for 1 of 2 (Resident # 167) residents reviewed for Physician Visits. The deficient practice was evidenced by the following: A review of Resident # 167's Electronic Medical Record (EMR) revealed he/she was admitted in NJ Ex Order 26.4(b)(1). A review of Resident # 167's EMR revealed he/she was diagnosed with but not limited to NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)). A review of the Progress Notes for Resident # 167 revealed a late entry by a US FOIA (b)(6) that was created on NJ Ex Order 26.4(b)(1) and dated for NJ Ex Order 26.4(b)(1). A review of Resident # 167's EMR did not reveal any other documented visits from the US FOIA (b)(6). A review of the Progress Notes revealed the Resident was seen by the US FOIA (b)(6) on the following dates: NJ Ex Order 26.4(b)	F0712	Continued from page 4 ELEMENT ONE: CORRECTIVE ACTION: Resident 167 seen the attending physician on NJ Ex Order 26.4 NJ Ex Order 26.4, and NJ Ex Order 26. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents' charts were audited for timely Physician visits. ELEMENT THREE: SYSTEMIC CHANGES: All new admissions/re-admissions will be audited by the medical records personal 2x a week for 3 months for compliance and results shared with the QAPI quarterly meeting. Education on timeliness, frequency and documentation of the visits was conducted by the LNHA to the U.S. FOIA (b) (6) for Resident 167. ELEMENT FOUR: QUALITY ASSURANCE: Medical records personal or designee will notify the DON or Administrator if any physicians visits are not completed timely. In addition, medical records personnel/designee will notify identified Physician. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x4 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Compliance: 11/14/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0712 SS = E	Continued from page 5 NJ Ex Order 26.4(b) [redacted] On 09/23/2025 at 10:59 AM during an interview with the Surveyor, the U.S. FOIA (b) (6) said that the requirement for physician visits in the facility occur at thirty, sixty, ninety, and one-hundred and twenty days. She concluded that after the ninetieth day, the US FOIA (b)(6) can share with the US FOIA (b)(6) On 09/24/2025 at 10:25 AM during an interview with the Surveyor, the U.S. FOIA (b) (6) confirmed that prior to NJ Ex Order 26.4(b)(1), the U.S. FOIA (b) (6) for Resident # 167 was identified by the facility as being NJ Exec Order 26.4b1 with physician visits. She said further that a new U.S. FOIA (b) (6) was installed in NJ Ex Or and physician visits have improved. At that time, the U.S. FOIA (b) (6) confirmed there is no further documentation that the attending US FOIA (b)(6) visited Resident # 167 during that time. A review of the facility provided policy titled, "Physician Visits" and revised in April of 2020 revealed that, "2. The Attending Physician must visit	F0712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0712 SS = E	Continued from page 6 his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter." § 8:39-23.2 (d)	F0712		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 09/18/2025 from 9:37 AM until 10:06 AM, the surveyor observed the following in the kitchen in the presence of the U.S. FOIA (b) (6)): 1.The Food Service Worker (FSW#1) had facial hair and was not wearing beard guard. The DD#1 stated the FSW#1 should have a beard guard.	F0812	Complete Care@Orange Park 140 Park Avenue East Orange, NJ 07017 Plan of Correction for Survey on 09-18-2025 F-812 FOOD PROCUREMENT, STORE/PREPARE/SERVE-SANITARY 483.60 CORRECTIVE ACTION: The outdated food items and fresh herbs that were found were immediately discarded. All kitchen staff were in-serviced by the Food Service Director on the proper labeling and dating, rotating of food, and discarding of outdated items The Manager or designee monitors these practices during their daily kitchen rounds to ensure staff is adhering to this practice. All employees without beard guards were immediately made aware of policy and in-serviced by the Food Service Director. All employees with facial hair shall put on beard guards prior to entering kitchen for shift and wear throughout their scheduled shift. HOW WILL THE FACILITY IDENTIFY AND PROTECT RESIDENTS IN A SIMILAR SITUATION? All residents at CompleteCare@Orange Park had the potential to be affected by labeling and dating deficient practices as well as foreign	11/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0812 SS = F	Continued from page 7 2. In the walk-in refrigerator, a prepared salad had a label which reflected prep 9/15 expire 9/17. The U.S. F stated it was out of date and threw the salad out. 3. In the walk-in refrigerator, a plastic bag of fresh basil dated 9/10 with soft brown areas on several leaves. The U.S. F stated the basil looks “a little soft gonna toss it.” 4. The Food Service Worker (FSW#2) had NJ Exec Order 26 and was not wearing beard guard. The U.S. F stated the FSW#2 should have a beard guard. A review of facility provided policy titled, "Beard Guard Policy", with a revision date of 6.2024 reflected: all dietary staff with facial hair that is not clean-shaven are required to wear an appropriate beard guard while working in food preparation, service, or storage areas. A review of the facility provided policy titled, "Labeling and Dating System Protocol/Policy", revised 7/2025 reflected: all fresh and frozen foods must be dated with the date it was received in the kitchen unless it has a purveyor shipping label on it, all food items must be properly labeled, dated, and always covered, and produce facility cut up and prepped exception tomato and lettuce 3 days. A review of the facility provided policy titled, “Dating and Storage of Fresh Herbs”, with a revision date reflected: discard herbs that are slimy, moldy. NJAC 8:39-17.2(g)	F0812	Continued from page 7 contamination(hair in food). The Kitchen has immediately refrained from occurrences associated with these deficient practices and the entire dietary staff has been educated by the Food Service Director. An opening and closing daily checklist has been implemented per policy to monitor all kitchen deficiencies from the survey. SYSTEMATIC CHANGE: Daily department rounds are conducted by the Food Service Director or designee to monitor that the labeling and dating in-services and training are being adhered to by staff. Beard guards are deemed part of daily uniforms for implied employees. Cooks are to check daily before the end of their shift to make sure that all items in the refrigerator and freezer are labeled and dated properly. All items that were found not labeled properly are corrected and reported to the manager for follow-up and course of action to the rectified situation. The Food Service Director or designee reviews all closing opening and closing checklists, and labeling and dating weekly for follow-up on issues or concerns. MONITORING OF CORRECTIVE ACTION: For the next 30 days, the Food Service Director or designee continuously monitors these practices during their daily kitchen round to ensure staff is adhering to these practices. After the 30 days are done the Food Service Director or designee will monitor these deficiency practices monthly and reporting findings with an action plan to the QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0812 SS = F		F0812	Continued from page 8 The Food Service Director and Regional manager or designee documents all findings from their daily kitchen rounds and reports findings with an action plan to the QAPI committee. Compliance Date: 11/14/25	
F0919 SS = E	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that the resident call bell system was properly functioning in all areas. This deficient practice had the potential to affect 3 residents and was evidenced by the following: Observations on 09/19/2025 from 10:14 AM to 11:01 AM revealed the following:The call bell cord was missing from resident room [redacted] The resident was in bed at the time. The surveyor asked the resident how long the call bell cord has been missing and the resident stated, "For a couple of days". Additionally, there was no indication that the call bell cord was missing at the call bell system annunciator panel.Visual notification of the activation of the call bell system was not provided at the call bell annunciator panel when testing the call bell for resident room [redacted] The indicating bulb was not functioning.The call bell did not activate when tested by the [redacted] for resident room [redacted]-window bed.	F0919	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 F 0919 Resident Call system SS-E ELEMENT ONE: CORRECTIVE ACTION: Residents in room [redacted] and [redacted] window were immediately given a call bell. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: A facility wide audit of every room was completed by Maintenance to ensure all residents have a working call bell. ELEMENT THREE: SYSTEMIC CHANGES: Maintenance or designee will audit all floors, all rooms monthly and retain as a standard protocol. Staff educated by the Maintenance Director to alert Maintenance/DON/LNHA of any non-functioning/missing call bells. Residents were educated by the Recreation Director at monthly resident council to alert staff of any equipment that needs attention. ELEMENT FOUR: QUALITY ASSURANCE: Maintenance will let the administrator or DON if there are any call bells that are not properly functioning Needed corrections will be addressed as they are discovered.	11/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
F0919 SS = E	Continued from page 9 In interviews at the time, the [redacted] confirmed the observations. The facility's [redacted] and [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e), 31.8(c)9	F0919	Continued from page 9 Findings to be reported monthly x4 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Compliance: 11/14/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060722	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S0000		11/14/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Findings include: A.) Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift.	S0560	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 S0560 Mandatory Access to Care ELEMENT ONE: CORRECTIVE ACTION: No residents were identified nor immediately affected by the failure to provide minimum staffing levels. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have the potential to be affected by this deficient practice. ELEMENT THREE: SYSTEMIC CHANGES: Staffing coordinator will inform DON or designee of any issues that result in insufficient staffing levels. This will be reported as soon as possible. Any staffing deficiencies will be filled prior to the start of the shift with other associates or agencies as needed. Facility has signed multiple Agency contracts to assist in meeting the required staffing. In addition, monthly job fairs are being held to assist in recruitment. Large company wide job fair was held on 9/10/25. Orange	11/14/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060722	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
S0560	Continued from page 1 One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 07/06/2025 to 07/12/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/06/25 had 21 CNAs for 202 residents on the day shift, required at least 25 CNAs. -07/07/25 had 20 CNAs for 201residents on the day shift, required at least 25 CNAs. -07/08/25 had 20 CNAs for 201 residents on the day shift, required at least 25 CNAs. -07/09/25 had 21 CNAs for 198 residents on the day shift, required at least 25 CNAs. -07/10/25 had 22 CNAs for 196 residents on the day shift, required at least 24 CNAs. -07/11/25 had 22 CNAs for 196 residents on the day shift, required at least 24 CNAs. -07/12/25 had 22 CNAs for 196 residents on the day shift, required at least 24 CNAs. 2. For the 2 weeks of staffing prior to survey, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -08/31/25 had 21 CNAs for 200 residents on the day shift, required at least 25 CNAs. -09/01/25 had 22 CNAs for 200 residents on the day shift, required at least 25 CNAs. -09/02/25 had 19 CNAs for 200 residents on the day shift, required at least 25 CNAs.	S0560	Continued from page 1 Park successfully hired 11 C.N.A.'s, 2 LPNs, and 1 R.N. Monthly DON meetings to discuss concerns, needed items and updates on facility to aid communication and early detection of potential employee concerns. Any concerns identified at DON monthly meetings will be addressed with appropriate parties and Human Resources to mitigate any staff members' concerns. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance: The DON or designee will report any staffing issues daily to the Administrator or designee. Any concerns identified at DON monthly meetings will be addressed with appropriate parties and Human Resources to mitigate any staff members' concerns. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary. Date of Compliance: 11/14/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060722	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
S0560	Continued from page 2 -09/03/25 had 21 CNAs for 198 residents on the day shift, required at least 25 CNAs. -09/04/25 had 21 CNAs for 198 residents on the day shift, required at least 25 CNAs. -09/05/25 had 21 CNAs for 198 residents on the day shift, required at least 25 CNAs. -09/06/25 had 22 CNAs for 198 residents on the day shift, required at least 25 CNAs. -09/07/25 had 20 CNAs for 199 residents on the day shift, required at least 25 CNAs. -09/08/25 had 22 CNAs for 196 residents on the day shift, required at least 24 CNAs. -09/09/25 had 21 CNAs for 196 residents on the day shift, required at least 24 CNAs. -09/10/25 had 23 CNAs for 196 residents on the day shift, required at least 24 CNAs. -09/11/25 had 23 CNAs for 196 residents on the day shift, required at least 24 CNAs. -09/12/25 had 23 CNAs for 199 residents on the day shift, required at least 25 CNAs. -09/13/25 had 21 CNAs for 199 residents on the day shift, required at least 25 CNAs. During an interview on 09/23/2025 at 11:32 AM with the surveyor, the Staffing coordinator (SC) said they try to meet staffing requirements, and they are almost there. The SC said they do job fairs every quarter and had a good turn out at the last one held on 09/10/2025. During and interview on 09/23/2025 at 11:59 AM with the surveyor, the Regional Clinical Director said after the last job fair on 09/10/2025 we will be meeting staffing requirements. A review of a facility provided policy titled, “Staffing” revealed, “Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.”	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060722	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
S0560		S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	**140 PARK AVE , EAST ORANGE, New Jersey, 07017**

(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) COMPLETION DATE
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/26/2025 in relation to the 9/24/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 060722	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/26/2025 in relation to the 9/24/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0000	INITIAL COMMENTS A Life Safety Code survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations from 09/18/25 to 09/22/25. Complete Care Orange Park was found to be in NON-COMPLIANCE with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies Complete Care Orange Park is a 4 -story building that was built in 80's, It is composed of Type II unprotected construction. The facility is divided into 14- smoke zones. The generator powers 100% of the building per the Maintenance Director. The building has a partial basement and 4 stories above ground. The basement contains the boiler room, sprinkler riser and the laundry areas. The ground floor is administrative office, kitchen, medical gas and vacuum supply rooms. Floors 1-3 are resident floors. Floors 1 and 2 have been renovated. Floor 1 contains a vent unit The census at the time of survey was 197 of 215.	K0000		11/14/2025
K0222 SS = F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all	K0222	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 K 222 Delayed egress HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The correct hardware was ordered and is back-order but will be replaced for the following exits near 329,208,230,120 and 108. The U.S. FOIA (b) (6) and maintenance staff were in serviced on properly functioning egress doors including ensuring latch is functioning properly.	09/25/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0222 SS = F	Continued from page 1 times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observations and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it	K0222	Continued from page 1 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected. An audit was completed on all egress doors to ensure proper functioning. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The maintenance director or designee will audit delayed egress exits for proper hardware to his quarterly maintenance checklist. Needed corrections will be addressed as they are discovered. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will audit exit hardware quarterly, results of the audit will be submitted to the administrator at the quarterly QAPI meeting for review and revision as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0222 SS = F	Continued from page 2 was determined that the facility failed to ensure that doors equipped with delayed egress locking arrangement were properly functioning in accordance with NFPA 101:2012 Edition, Sections 7.2.1.6.1 and 19.2.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 09/19/2025 from 10:29 AM to 11:28 AM revealed that exit stairway enclosure doors in the following areas were equipped with delayed egress locking arrangements: Exits near resident rooms 329,208,230, 120 and 108. When a force not exceeding 15 pounds was applied for up to 3 seconds, the locking mechanism did not initiate the irreversible release process within the required 15 seconds unless the lever handle was manually turned to unlatch the lock before application of force. In interviews at the time, the U.S. FOIA and the U.S. FO confirmed the observations. The facility's U.S. FOIA (b) (6) U.S. FOIA and U.S. FO were informed of the deficient practice(s) at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e)	K0222		
K0223 SS = F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and	K0223	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 K 223 Doors with self -closing device. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The block of wood was removed from back exit door on 9/22/25 and the armature plate was put back on the door. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	11/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0223 SS = F	Continued from page 3 * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observations and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that doors in a stairway enclosure were kept closed unless held open by a releasing device that automatically closed such doors upon activation of the fire alarm system in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.7 and 19.2.2.2.8. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 09/22/2025 at 10:42 AM revealed that the exit stairway enclosure door on the first floor was being held open by a block of wood. Upon further investigation it was noticed that the armature plate for the electromagnetic releasing device was missing from the door. In an interview at the time, the U.S. FO confirmed the observation. The facility's U.S. FOIA (b) (6) U.S. FOIA and U.S. FO were informed of the deficient practice at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e)	K0223	Continued from page 3 All residents can be affected by this. An audit of stairway self-latching doors was completed. corrections were made as discovered. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The maintenance director will add stairway self-closing and latching device audit to his quarterly maintenance checklist. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will audit stairway self-closing and latching device quarterly, needed corrections will be addressed as they are discovered, with results submitted to the QAPI committee quarterly for review and revision as needed.	
K0342 SS = F	Fire Alarm System - Initiation CFR(s): NFPA 101 Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded.	K0342	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 K 342 Fire Alarm system Initiation 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Manual fire alarm boxes were lowered to the correct height by room 208,230 and near the nurses station	11/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0342 SS = F	Continued from page 4 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This STANDARD is NOT MET as evidenced by: Based on observations and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) it was determined that the facility failed to ensure that all manual alarm boxes were installed and accessible (between 42 and 48-inches) in accordance with NFPA 101:2012 Edition, Sections 9.6.2.5, 19.3.4.2.1 ,19.3.4.2.2, NFPA 70 and NFPA 72: 2010 Edition, Sections 17.14.4 – 17.14.6. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 09/18/2025 from 11:00 AM to 12:10 PM revealed the following: The operable part of the manual alarm box near resident rooms NJ Exec Order 2 and near the nurse's station on the second floor were 62-inches above the finished floor.The new exit door in the basement was not provided with a manual alarm box within 60-inches of the exit doorway opening. In interviews at the time, the NJ Ex Orc and the NJ Ex C confirmed the observations and stated, "All the manual alarm boxes on each floor in the facility are installed at the same height" and "Quotes have been received for installation of a manual alarm box for the new basement exit". The facility's U.S. FOIA (b) (6) U.S. FOIA and U.S. FO were informed of the deficient practice(s) at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 70, 72	K0342	Continued from page 4 The exit door in the basement had a manual alarm box added within 60 inches 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The U.S. FOIA (b) (6) was educated by the administrator on 9/22/25 on having the alarm boxes at the correct height 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The maintenance Director or designee will audit the manual alarm boxes for the correct height by room 208,230,and 320 and the alarm box by the basement exit monthly x 3 months. Needed corrections will be addressed as they are discovered, with results presented quarterly to QAPI committee for review and revision as necess	
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K0353	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 K 353 Sprinkler maintenance and testing. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE:	09/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0353 SS = F	Continued from page 5 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that the automatic sprinkler system was Inspected, Tested and Maintained in accordance with NFPA 101:2012 Edition, Sections 9.7.5 and NFPA 25:2011 Edition, Section 5.2. This deficient practice had the potential to affect all residents and was evidenced by the following: A observations at 10:54 AM on 09/22/2025 revealed that an escutcheon was not provided around the sprinkler head in resident room NJ Exe closet. Observations from 11:10 AM to 12:49 PM revealed that the sprinkler heads in the following areas contained a heavy loading of foreign material that could prevent and or delay the activation of the sprinkler head in an emergency:Second floor day room near HVAC vents (2)Second floor nurses' station (2)First floor day room (1)Ground floor lobby area and near HVAC vents (2). In interviews at the time, the U.S. FOIA and the U.S. FO confirmed the observations. The facility's U.S. FOIA (b) (6) U.S. FOIA and U.S. FO were informed of the deficient practice(s) at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 25	K0353	Continued from page 5 An escutcheon ring was installed on 215 closets on 9/22/25. The sprinkler heads in the following areas, second floor day, second floor nurse station, first floor day room and ground floor lobby were cleaned on 9/22/25. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this practice. The maintenance director completed an audit on all sprinkler heads to ensure were clean. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The U.S. FOIA (b) (6) and department were in serviced on proper presentation of sprinkler had (free of debris and all parts present) The Maintenance staff will conduct monthly inspections of sprinkler heads to ensure sprinkler heads are clean and free of missing parts. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Maintenance staff will inspect sprinkler heads monthly x 3 months followed by quarterly x3. Needed corrections will be addressed as they are discovered. All results will be reported to QAPI committee quarterly for review and revision as needed. Completion date: 9/24/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - MAIN BUILDING 0... B. WING	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0353 K0355 SS=F SS = D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observations and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that portable fire extinguishers were Inspected, Tested and Maintained (ITM) in accordance with NFPA 101:2012 Edition, Section 19.3.5.12 and NFPA 25: Chapter 7. This deficient practice had the potential to affect all residents on the unit and was evidenced by the following: Observations on 09/19/2025 from 9:57 AM to 10:28 AM revealed that the fire extinguishers near resident rooms [redacted] and [redacted] were missing their inspection tags. In interviews at the time, the [redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) [redacted] and [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 10	K0353 K0355	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 K 355 portable fire extinguishers 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The fire extinguisher located near room 320 and 328 had their inspection tags added on 9/19/25 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this. An audit was conducted on 9/19/25 to ensure all portable fire extinguishes are properly dated. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The U.S. FOIA (b) (6) and maintenance team was educated by the administrator on 9/19/25 on the fire extinguisher inspection tags regulation. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Maintenance director or designee will audit fire extinguisher tags for proper placement monthly x 3 needed corrections will be addressed as they occur, with the results presented to the QAPI committee monthly review and revision as necessary.	09/25/2025
K0363 SS = F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20	K0363	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 K 363 corridor doors 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE:	09/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0363 SS = F	Continued from page 7 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observations and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that doors in the corridor: A) positive latched, B) could resist the passage of smoke and C) were provided with a means to keep the door fully closed if a force of 5LBS is applied to the latch edge of the door in accordance with NFPA 101:2012 Edition, Section 19.3.6.3, 19.3.6.3.5 , and CFR Parts 403,418,460,482,483 and 485. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 09/22/2025 from 10:06 AM to 12:30 PM revealed the following:The third-floor pantry, oxygen storage room and the exit door near the maintenance office did not positive latch when tested by the U.S. FO Additionally, the exit door near the employee break room on the ground floor was not equipped with latching hardware.The “Day Room” French doors on floors 1,2 and 3 could not stay closed when force was applied to the	K0363	Continued from page 7 The third-floor pantry, oxygen storage room and exit door near the maintenance office had a positive latch installed on 9/22/25 The exit door near the employee break room on the ground floor was fixed with latching hardware 9/22/25 The day room French doors on 1,2 and 3 were fixed to be able to stay closed when force was applied on 9/22/25 The vent mechanical room had a 20 inch louvered vent in the door which was repaired on 9/22/25 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected by this deficient practice. A facility wide audit was completed on all corridor doors for hardware, warping and ability to resist the passage of smoke 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: U.S. FOIA (b) (6) and team educated by regional maintenance director on corridor door inspections to ensure proper latching, hardware is intact, there is no warping and has the ability to resist passage of smoke. Corridor door inspections will be added to the weekly preventative maintenance schedule. They will be assessed for hardware, warping and ability to resist the passage of smoke. Needed corrections will be addressed as they are discovered. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The maintenance director/designee will audit 5 random doors to ensure positive latching, hardware is intact, there is no warping and ability to resist the passage of smoke are intact, monthly x3 months. Needed corrections will be addressed as they are discovered, with the results reported to the QAPI committee quarterly for review and revision as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - MAIN BUILDING 0... B. WING	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0363 SS = F	Continued from page 8 latch edge.The "Vent Unit Mechanical Room" contained a 20-inch by 26-inch louvered vent in the corridor door. In interviews at the time, the U.S. FOIA and the U.S. FOIA confirmed the observations. The facility's U.S. FOIA (b) (6) U.S. FOIA and U.S. FOIA were informed of the deficient practice(s) at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e)	K0363		
K0531 SS = F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on observation and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that elevators were Inspected, Tested and Maintained (ITM) in accordance with NFPA 101:2012 Edition, Section 9.4 and ASME A17.1, Safety Code for Elevators and Escalators. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0531	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 K 531 Elevators 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The 2 way voice communication in elevator 2 was fixed on 10/28/25 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected who utilize the elevator can be affected. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The U.S. FOIA (b) (6) was educated by the administrator on 9/20/25 on inspecting the all the elevators 2 way voice communication monthly. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: the maintenance Director or designee will audit monthly on the function of the 2-way voice communication on all elevators, needed corrections will be addressed as they occur. Results presented quarterly to QAPI committee for review and revision as needed.	10/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0531 SS = F	Continued from page 9 An observation on 09/19/2025 at 10:44 AM revealed that the emergency two-way voice communication system in Elevator 2 did not function when tested by the U.S. FO In an interview at the time, the U.S. FO confirmed the observation. The facility's U.S. FOIA (b) (6) U.S. FOIA and U.S. FO were informed of the deficient practice at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e) ASME A17.1	K0531		
K0908 SS = F Bldg. 01	Gas and Vacuum Piped Systems - Inspection and CFR(s): NFPA 101 Gas and Vacuum Piped Systems - Inspection and Testing Operations The gas and vacuum systems are inspected and tested as part of a maintenance program and include the required elements. Records of the inspections and testing are maintained as required. 5.1.14.2.3, B.5.2, 5.2.13, 5.3.13, 5.3.13.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on a record review and interviews from 09/18/2025 to 09/22/2025 in the presence of the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that medical gas and vacuum piped systems were Inspected, Tested and Maintained (ITM) in accordance with NFPA 99:2012 Edition, Chapter 5. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 09/18/2025 revealed that a current medical gas systems maintenance inspection, established through risk assessments, could not be found in the documentation that the facility provided for review. Additionally, the provided inspection report, conducted on 01/18/2024 (over 20 months ago) did not designate the system as a Category 1-3. In an interview at the time, the U.S. FO confirmed the	K0908	Complete Care at Orange Park Facility ID 315178 Survey date 9/24/25 K 908 Gas and Vacuum Piped Systems - Inspection and Testing Operations HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: The correct inspection was scheduled for November and will be designated as a Category 1-3 HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents can be affected. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: The U.S. FOIA (b) (6) and maintenance team were educated by the Administrator on 9/22/25 on the importance of having these inspections scheduled timely. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR,	11/18/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0908 SS = F Bldg. 01	Continued from page 10 record review and stated that they are scheduled for an inspection in November. The facility's U.S. FOIA (b) (6) U.S. FOIA and U.S. FO were informed of the deficient practice at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K0908	Continued from page 10 I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: the maintenance Director or designee will audit every 6 months on making sure the inspection is scheduled , and report results directly to Administrator every 6 months and quarterly to QAPI committee for review and revision as needed. Completion date 9/24/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness survey was conducted from 09/18/2025 to 09/22/2025 and the facility was found to be Compliant with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		11/14/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315178	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ORANGE PARK	140 PARK AVE , EAST ORANGE, New Jersey, 07017

(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) COMPLETION DATE
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 2/11/2026 in relation to the 9/24/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.	K0000		02/11/2026

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 reverse for further 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