New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061217	A. BUILDING: _____ B. WING _____	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	**625 STATE HIGHWAY 34 MATAWAN, NJ 07747**

(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
S 000	Initial Comments An Initial Approval survey was conducted on 09/10/2024 for the Dialysis Den project. The facility was found to be non-compliant with LTC-LSC regulations.	S 000		

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

Electronically Signed — 12/06/24

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	315015	A. BUILDING **01** B. WING _____	**09/10/2024**

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E 000	Initial Comments This facility was not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 006 SS=D	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E 006		10/15/24

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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 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.

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E 006	Continued From page 1 (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 09/10/2024 in the presence of Facility Management, it was determined that the facility failed to include that the Dialysis Den staff and resident needs were included in the risk assessment and policy and procedures for	E 006	Immediate corrective action for residents affected by this deficient practice: " The Facility Emergency Preparedness Manual was updated to include the Dialysis Den staff and Residents□ needs in the event of an emergency.	

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E 006	Continued From page 2 Emergency Preparedness in the Long-Term Care (LTC) plan in accordance with Appendix Z. This deficient practice had the potential to affect Dialysis Den staff and residents and was evidenced by the following: At 12:45 PM, a review of the Emergency Preparedness Manual for the Dialysis contracted provider and the Long-Term Care facility revealed there was no inclusion of Dialysis Den staff and residents included in the LTC plan. The Dialysis plan stated they would follow the Long-Term Care facility plan. The plans also did not include a plan or contract to transport and provide dialysis services at alternate facilities in the event of a disruption. In an interview at the time, the facility's US FOIA (b)(6) confirmed the findings. NJAC 8:39-31.2(e)	E 006	Identify those individuals who could be affected by tis deficient practice: " All Dialysis Den staff and Residents have the potential to be affected by this deficient practice. " No adverse effects of the deficient practice were noted for any residents. Measures put in place to ensure the deficient practice will not occur for those residents affected: " The Administrator provided education to the facility staff emphasizing that the Dialysis Den is included in the facility Emergency Preparedness Manual. Monitoring of measures or systemic changes to ensure that the deficiencies will not recur: " The Maintenance Director/Designee will conduct audits and review the Emergency Preparedness manual to ensure it is updated in a timely manner with all Emergency Preparedness information related to the Dialysis Den staff and residents. " Audits will be completed weekly x4 weeks and then monthly x2 months or until compliance is met. " Results of audits will be reported to the QAPI committee. The QAPI committee meets quarterly.	
K 000	INITIAL COMMENTS Dialysis Den Project Survey A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/10/24 was found to be in noncompliance with the	K 000		

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K 000	Continued From page 3 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 Madison renovated an existing Dialysis Center to a Dialysis Den for inpatient services.	K 000		
K 241 SS=D	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Based on observations, documentation review and interview on 09/10/2024 in the presence of Facility Management, it was determined that the facility failed to provide 2 exits remote from one another to minimize the possibility that more than one has the potential to be blocked by any one fire or other emergency condition in accordance with NFPA 101:2012 Edition, Section 7.5.1.3.1. This deficient practice had the potential to affect Dialysis Den staff and residents and was evidenced by the following: Observations of the Dialysis Den at 11:45 AM, revealed there were 2 exits provided. One exit	K 241	E K 241 Two Means of Egress The POC must include the following information: 1. Facility requesting a time-limited waiver and the reason for the request: Complete Care at Madison is requesting a time-limited waiver to meet the requirements outlined in the life safety deficiency EK 241. This work will require architectural design work, as well as approvals from NJ DCA, NJ DOH CON/	1/13/25

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K 241	Continued From page 4 was thorough the main entrance way and the second was located at the end of the service corridor. Observations revealed that if the exit way through the main entrance was obstructed due to fire or other emergency, the access to the service corridor exit would also be obstructed as the entrance to the service corridor was located directly adjacent to the main entrance/exit door. This condition would leave Dialysis Den staff and residents with no exit from the Dialysis Den dialyzing area. A review of the posted evacuation plan diagram confirmed these were the only 2 available exits. In an interview at the time, the facility's maintenance staff and US FOIA (b)(6) confirmed the findings. NJAC 8:39-31.2(e)	K 241	Licensing, and the local building department. 2. Specific actions the facility will take to correct the deficiency and the estimated completion date: The facility has retained NJ Exec Order 26.4b [redacted] to rework the floor plan and provide two remote exits. The projected timeline for this project is several months and is provided below. 3. Measures to keep residents, staff, and visitors safe from harm during the waiver period: All facility staff have been educated on the current common pathway and the two available means of egress. Staff have been trained to ensure the pathway always remains unobstructed. the Dialysis Treatment area remains off limits to Residents and Staff. 4. Alternate life safety measures during the waiver period (above minimum regulatory requirements): An additional fire extinguisher will be placed in the dialysis area and a evacuation drill will be conducted quarterly in the dialysis area. 5. Person responsible for monitoring the facility during the waiver period and monitoring frequency: The Administrator or Maintenance Director, will keep the Dialysis treatment	

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K 241	Continued From page 5	K 241	area off limits to residents and staff during the waiver period. Signage will be posted and the area will be checked daily. 6. Timetable of milestones with start and end dates: TASK Architectural Design Start 12/9/2024 end 1/23/2025 DOH Review/ Approval Start 1/23/2025 End 3/24/2025 DCA Review/ Approval Start 3/24/2025 End 5/23/2025 Local Building and Zoning Review/ Approval Start 5/23/2025 End 6/22/2025 Construction Start 6/22/2025 End 7/22/2025 Local Building and Zoning Inspection and CO Start 7/22/2025 end 8/21/2025 DOH Inspection Start 8/21/2025 end 9/20/2025 7. Role of QAPI and meeting frequency: The Administrator will review updates on progress during the center□s Quarterly QAPI meetings and adjust plans as needed.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101	K 293		10/15/24

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K 293	Continued From page 6 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/10/2024 in the presence of Facility Management, it was determined that the facility failed to ensure emergency exit directional lights were maintained in operating condition in accordance with NFPA 101:2012 Edition, Section 19.2.10.1. This deficient practice had the potential to affect Dialysis Den staff and residents and was evidenced by the following: An observation of the front exit area at 10:15 AM, revealed the exit light/directional sign was not illuminated. In an interview at the time, maintenance staff confirmed the finding. NJAC 8:39-31.1(c), 31.2(e)	K 293	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: An lighted exit sign was installed 2. How the facility will identify other resident having the potential to be affected by the deficient practice: All Dialysis Den staff and Residents have the potential to be affected by this deficient practice. No adverse effects of the deficient practice were noted for any residents. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: The US FOIA (b)(6) was in serviced by the administrator on the requirements for lighted exit signage. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. the maintenance director will audit exit signage for placement and visibility. Audits will be conducted weekly x 4 then monthly x 2 with results reported to the	

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K 293	Continued From page 7	K 293	QAPI committee. The QAPI committee meets quarterly	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 09/10/2024 in the presence of facility	K 321	1. How the corrective action will be accomplished for those residents found to	10/1/24

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K 321	Continued From page 8 management, it was determined that the facility failed to provide hazardous storage areas with self-closing doors in accordance with NFPA 101:2012 Edition, Sections 19/3/2/1 and 19.3.5.9. This deficient practice had the potential to affect Dialysis Den staff and residents and was evidenced by the following: An observation of the Dialysis Den corridor at 10:45 AM, revealed there were 3 storage rooms for combustible materials that were not provided with a self-closing door. These rooms measured greater than 50-square feet in size and contained combustible paper storage. In an interview at the time, the facility's US FOIA (b)(6) confirmed the findings and stated it was storage of supplies and medical records for the Long-Term Care unit. NJAC 8:39-31.2(e)	K 321	have been affected by the deficient practice: Door closures were installed on all 3 storage rooms. 2. How the facility will identify other residents having the potential to be affected by the deficient practice: All Dialysis Den staff and Residents have the potential to be affected by this deficient practice. No adverse effects of the deficient practice were noted for any residents. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: The US FOIA (b)(6) was in-serviced on the requirement for storage rooms needing an auto closure. 4. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. The maintenance director or designee will audit storage rooms for proper door closure. Audits will be conducted weekly x 4 them monthly x 2 with the results reported to the QAPI committee the QAPI committee meets quarterly.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		10/1/24

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K 351	Continued From page 9 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 09/10/2024 in the presence of Facility Management, it was determined that the facility failed to provide automatic fire sprinkler protection to overhangs in accordance with NFPA 101:2012 Edition, NFPA 13:2010 Edition. This deficient practice had the potential to affect Dialysis Den staff and residents and was evidenced by the following: An observation of the Dialysis Den entrance at 11:30 AM, revealed there was a large cloth covered awning attached to the building above the sidewalk. The awning was greater than 4-foot wide and was not provided with fire sprinkler protection. In an interview at the time, the facility's maintenance staff confirmed the finding. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: The cloth awning was removed there are no other awning areas that do not have sprinkler coverage. 2. How the facility will identify other residents having the potential to be affected by the deficient practice: All Dialysis Den staff and Residents have the potential to be affected by this deficient practice. No adverse effects of the deficient practice were noted for any residents. 3. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not recur: The US FOIA (b)(6) was in-serviced on the requirement sprinkler coverage by the administrator 4. How the facility will monitor its corrective actions to ensure that the	

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K 351	Continued From page 10	K 351	deficient practice will not recur. The maintenance director or designee will audit awnings sprinkler coverage. Audits will be conducted weekly x 4 them monthly x 2 with the results reported to the QAPI committee the QAPI committee meets quarterly.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315015 Y1	A. Building B. Wing Y2	3/4/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 E0006 Reg. # 483.73(a)(1)-(2) LSC	Correction Completed 10/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315015 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/4/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT MADISON, LLC	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0241	10/15/2024	LSC K0293	10/15/2024	LSC K0321	10/01/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0351	10/01/2024	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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
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