STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING _____ B. WING _____	C 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PARK PLACE, LLC	2 DEER PARK DRIVE MONMOUTH JUNCTION, NJ 08852

(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
F 000	INITIAL COMMENTS A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00163941 and NJ00162670 Survey Dates: 06/04/23 through 06/06/23 Survey Census: 80 Sample Size: 12 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those	F 790		7/12/23

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

Electronically Signed | 07/12/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING _____ B. WING _____	C 06/06/2023

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COMPLETE CARE AT PARK PLACE, LLC	2 DEER PARK DRIVE MONMOUTH JUNCTION, NJ 08852

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F 790	Continued From page 1 circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to order a [redacted] consult in a timely manner for one resident in a total sample of 12 (Resident (R)11) who was reviewed for dental. This failure placed the resident at risk for unmet care needs and a diminished quality of life. Findings include: Review of the "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed R11 was admitted to the facility on [redacted] with diagnoses that included [redacted]] [redacted].	F 790	It has been identified that a resident in the facility has had an order for [redacted] consultation that has not been carried out or followed up on. The [redacted] appointment was immediately scheduled, and residents seen with new recommendations. All residents have the potential to be affected by this deficient practice. Facility educator in-serviced all nursing staff on how to use communication tab. Audit completed to identify any missing consultations. Communication tab on	

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	315362	A. BUILDING _____ B. WING _____	C 06/06/2023

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COMPLETE CARE AT PARK PLACE, LLC	2 DEER PARK DRIVE MONMOUTH JUNCTION, NJ 08852

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F 790	Continued From page 2 Review of the admission "Minimum Data Set (MDS)" located the "MDS" tab of the EMR with an Assessment Reference Date (ARD) of [redacted], revealed, R11 had a "Brief Interview for Mental Status (BIMS)" of [redacted] which indicated R11 was [redacted] for daily [redacted] and had no [redacted] issues. A "Physician Note," located in the "Progress Notes" tab of the EMR, dated [redacted] at 1:17 PM revealed, " ...Seen at bedside ... [redacted] eval ...case rev [reviewed] with RN at time of visit ..." Review of the "Progress Notes" from [redacted] to [redacted] revealed no referral to the dentist had occurred. Review of the "Physician Orders," from [redacted] to [redacted] and located in the "Orders" tab revealed no physician order for a [redacted] referral for [redacted] infection. During an observation and interview on 06/05/23 at 8:52 AM, R11 was sitting up in bed, with [redacted] breakfast tray in front of [redacted]. R11 was asked if she had been provided with a [redacted]t appointment due to [redacted]. She stated, "No, they have not informed me of any [redacted] appointment." During an interview on 06/05/23 at 11:30 AM, the Unit Clerk was asked if an appointment had been scheduled R11. She stated, "I haven't scheduled [redacted] yet. This is the first time I am hearing about it." During an interview on 06/05/23 at 11:43 AM, Registered Nurse Supervisor (RNS) 2 was asked if R11 had been provided an appointment with the	F 790	electronic medical record implemented to communicate needed consultations and appointments to the Unit clerk. The unit clerk follows up and communicates back once the appointment and or consult is made. Director of nursing and or Assistant director of nursing will audit communication tab to ensure it□s being used properly weekly x 4, monthly x2. Results of these findings will be reported to the Administrator at Quality assurance performance improvement (QAPI) meeting.	

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	315362	A. BUILDING _____ B. WING _____	C 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PARK PLACE, LLC	**2 DEER PARK DRIVE MONMOUTH JUNCTION, NJ 08852**

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F 790	Continued From page 3 dentist. He stated that R11 had refused to see the [redacted] on [redacted] (prior to progress note of [redacted] however, she was put on a list to be seen on [redacted] During an interview on 06/05/23 at 2:39 PM, the Director of Nursing (DON) was asked what her expectation was for a resident who was having [redacted]. She stated that staff should attempt to call the [redacted] and schedule an appointment. NJAC 8:39-15.1 (a) (b)	F 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061345	A. BUILDING: _____ B. WING _____	C 06/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PARK PLACE, LLC	2 DEER PARK DRIVE MONMOUTH JUNCTION, NJ 08852

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S 000	Initial Comments Complaint #: NJ00163941 and NJ00162670 Survey Dates: 06/04/23 through 06/06/23 Survey Census: 80 Sample Size: 12 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 8 of 28 day shifts as follows: This deficient practice had the potential to affect all residents. Findings include:	S 560	1) a) Center staffing ratios as required by NJDOH were communicated to staffing coordinator and all Nurse managers and supervisors to match ratios of 1:8 on day shift; 1:10 on evening shift and 1:14 on night shift b) Center staffing schedule ratios are developed, reviewed and posted two	7/12/23

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

Electronically Signed | 07/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061345	A. BUILDING: _____ B. WING _____	C 06/06/2023

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S 560	Continued From page 1 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 as 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. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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. As per the "Nurse Staffing Report" completed by the facility for the 4 weeks of staffing from 02/05/2023 to 02/18/2023 and 05/21/2023 to 06/03/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: 1. For the 2 weeks of complaint staffing from 02/05/2023 to 02/18/2023, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -02/05/23 had 9 CNAs for 85 residents on the day shift, required 11 CNAs.	S 560	weeks prior to utilization to comply with required staffing ratios. c) Administrator, DON and Staffing Coordinator meet every morning to go over daily staffing sheets and look ahead at copies of projected schedule for the next two weeks to ensure required staffing ratios. d) DON, Administrator and staffing coordinator meet weekly to review the 4 week master schedule to ensure facility has staff that meets the needs. 2) All residents have potential to be affected by the same deficit practice. 3) a) If staffing deficits on master staffing schedule are identified, Center will communicate all unfilled shifts to in-house staff for coverage. b) Center will continue external recruitment efforts to fill open positions and review and revise as necessary c) Center will maintain multiple contacts with staffing agencies to meet required staffing ratios and review as necessary d) Center will continue to offer bonus structure to incentivize staff to fill shifts if needed and revise as necessary. e) Center will continue to make efforts to retain staff by way of employee engagement events. 4) a) Center Staffing Coordinator will review projected census and staffing ratio to assure staffing compliance. b) Administrator, DON, and Staffing Coordinator will continue to meet daily to go over projected staffing to assure required staff ratios. c) If ratios are projected to not be	

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S 560	Continued From page 2 -02/11/23 had 9 CNAs for 83 residents on the day shift, required 10 CNAs. -02/12/23 had 9 CNAs for 87 residents on the day shift, required 11 CNAs. -02/14/23 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. -02/17/23 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. -02/18/23 had 9 CNAs for 93 residents on the day shift, required 12 CNAs. 2. For the 2 weeks of staffing prior to survey from 05/21/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -05/21/23 had 8 CNAs for 86 residents on the day shift, required 11 CNAs. -06/03/23 had 9 CNAs for 83 residents on the day shift, required 10 CNAs.	S 560	met, Center will post openings for in-house staff as well as contact contracted agencies to maintain staffing compliance. d) DON/Staffing Coordinator will conduct daily staffing audits for two weeks and bi-weekly for two months. e) Results of the audits will be presented to the QAPI meetings for review and revision as deemed appropriate. 5) Interventions for compliance with S560 are in place. Administrator to monitor staffing post to see what happened and pre via measures listed above for ongoing compliance.	

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315362	A. Building B. Wing	7/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PARK PLACE, LLC	2 DEER PARK DRIVE MONMOUTH JUNCTION, NJ 08852

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 F0790 Reg. # 483.55(a)(1)-(5) LSC	Correction Completed 07/12/2023	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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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	
6/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061345		7/20/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PARK PLACE, LLC	2 DEER PARK DRIVE MONMOUTH JUNCTION, NJ 08852

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 07/12/2023	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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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	
6/6/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO