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 08/30/2024

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
E 000	Initial Comments This facility is 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		
F 000	INITIAL COMMENTS Complaint #: NJ167385, 168213, and 168532 Survey Date: 08/22/24 - 08/30/24 Census: 86 Sample: 18 + 2 closed record 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.	F 000		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow a physician's order for a resident who required a NJ Ex Order 26.4(b)(1)	F 695	An immediate NJ Ex Order 26.4(b)(1) and NJ Ex Order were ordered for resident #33. The resident's orders for # 33 were reviewed by Director of nursing and primary doctor	9/19/24

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

Electronically Signed | 09/17/2024

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 08/30/2024

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 695	Continued From page 1 NJ Ex Order 26.4(b)(1) at night. This deficient practice was identified for one (1) of two (2) residents reviewed for NJ Ex Order 26.4(b)(1) Care (Resident #33), and was evidenced by the following: During the initial tour of the facility on 8/22/24 at 09:35 AM, the surveyor observed an NJ Ex Order 26.4 near Resident #33's bed. At that time, the surveyor did not observe a NJ Ex Order 26 (NJ Ex Order 26.4(b)(1)) in the resident's room. According to the Admission Record, Resident #33 was admitted to the facility with diagnoses which included 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 Or . A review of the Order Details revealed a physician's order (PO) dated NJ Ex Order 26.4 at 5:06 AM, "Please assist pt [patient] in NJ Ex Order 26.4(b)(1) at HS [at night] please have NJ Ex Order 26.4(b)(1) come to ensure proper set-up." A review of the comprehensive Care Plan revealed a focus area of NJ Ex Order 26.4(b)(1) r/t [related to] NJ Ex Order initiated on NJ Ex Order 26.4(b). The interventions included, NJ Ex Order 26.4(b)(1) , also initiated on NJ Ex Order 26.4(b) . During an interview with the surveyor on 08/23/24 at 12:38 PM, Resident #33 stated that he/she NJ Ex Order 26.4(b)(1) at home. When asked did he/she wear the NJ Ex Order 26.4(b)(1) while at the facility? The resident stated, "NJ Ex Order 26.4(b)(1)	F 695	for accuracy. All residents with c-pap or respiratory equipment orders have the potential to be affected. The facility will conduct audits of physicians orders for all residents with respiratory orders. Director of nursing/designee to give ongoing mass education to all licensed nurses on carrying out physician orders, consult compliance and ensuring that equipment are available for use beginning 9/12/2024 and ending 9/19/2024 . All residents with respiratory equipment orders care plans will be reviewed during clinical meeting daily and updated accordingly. Director of nursing/designee will round weekly to ensure that all residents that need respiratory equipment have equipment in place for use. Audits will be conducted by Director of nursing/designee on 5 residents with respiratory orders, consult accuracy, and respiratory equipment needs once a week x 4 weeks then on 5 residents biweekly x 2 months. The results of the audit will submitted to the Quality Assurance Improvement Committee.	

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 08/30/2024

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 695	Continued From page 2	F 695		

NJ Ex Order 26.4

During an interview with the surveyor, the U.S. FOIA (b) (6)) stated that Resident #33 previously had a NJ Ex Order 26 and PO prior to being discharged to the hospital. At that time, the U.S. FOIA (b) (6 reviewed the resident's electronic medical record (EMR) and confirmed the above order and stated that if the resident had an order for a NJ Ex Order 26.4(b)(1), then he/she should have it.

During an interview with the surveyor on 8/27/24 at 12:15 PM, the U.S. FOIA (b) (6)) stated that based on the PO referenced above, a NJ Ex Order 26.4(b)(1) consult should have been completed and the agency that provided NJ Ex Order 26.4(b)(1) services should have been contacted. The U.S. FOIA reviewed the EMR and confirmed that a NJ Ex Order 26.4(b)(1) consult was not completed.

During an interview with the surveyor on 8/28/24 at 10:07 AM, the physician stated that Resident #33 required a NJ Ex Order 2 (NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1) and based on the PO referenced above, usually a NJ Ex Order 26.4(b)(1) would come to the facility to set up the NJ Ex Order 26.4(b)(1).

A review of the facility's PAP Equipment policy, dated reviewed 1/1/2023, included "2. Verify Medical Doctor order. 3. Gather necessary equipment."

NJAC 8:39-27.1(a)

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 08/30/2024

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) COMPLETE DATE
S 000	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.	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: Complaint #: NJ167385 and NJ168213 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratio, as mandated by the State of New Jersey, for 5 of 5 weeks of staffing prior to the recertification survey date 08/30/2024. This deficient practice was evidenced by the following: 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	S 560	Inadequate number of certified nursing assistants due to call offs and staff not reporting to work. All residents may be affected by the shortage of staff as required by NJ Department of Health. The administrator will in-service the staffing coordinator in reference to the state guideline S 560.In-service completed 9/16/2024. Director of Human Resources will continue to post vacancies for all 3 shifts. The staffing coordinator/designee will post and or offer overtime pay to in house staff. The facility is recruiting on multiple employment search engines and	9/19/24

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 08/30/2024

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) COMPLETE DATE
S 560	Continued From page 1 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 (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) 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 (1) 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. A review of the "Nurse Staffing Report" for the following weeks provided by the facility revealed the following: 1. For the 2 weeks of Complaint staffing from 09/03/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts as follows: -09/03/23 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. -09/09/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. -09/10/23 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -09/11/23 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. -09/12/23 had 10 CNAs for 91 residents on the	S 560	multiple social media platforms and has dedicated recruitment team. The staffing coordinator/ designee will audit the staffing weekly for 4 weeks then monthly for 3 months. The staffing coordinator and director of nursing will submit the audit report to the Quality Assurance Improvement Committee.	

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 08/30/2024

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) COMPLETE DATE
S 560	Continued From page 2 day shift, required at least 11 CNAs. -09/14/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. -09/16/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. 2. For the week of Complaint staffing from 10/01/2023 to 10/07/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -10/01/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. 3. For the 2 weeks of staffing prior to survey from 08/04/2024 to 08/17/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -08/04/24 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs. -08/05/24 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -08/06/24 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -08/07/24 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -08/09/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/10/24 had 9 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/11/24 had 9 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/13/24 had 10 CNAs for 85 residents on the day shift, required at least 11 CNAs. -08/15/24 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs. -08/16/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs.	S 560		

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 08/30/2024

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) COMPLETE DATE
S 560	Continued From page 3 -08/17/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. On 08/27/24 at 11:14 AM, the surveyor interviewed Certified Nursing Assistant (CNA #1) who stated that she had 11 residents today but was unsure of the census on the Garden (memory) Unit but thinks it was 39. When asked did she have enough time to perform care? She stated, "well we try." She emphasized she did not feel like it was short staffed and had everything she needed to provide care to the residents. On 08/27/24 at 11:28 AM, the surveyor interviewed Certified Nursing Assistant (CNA #2) who stated she had nine (9) residents today but was unsure of the census on the Terrace (subacute/LTC) Unit. She further stated that she generally had 12 or 13 residents during the day shift (7 AM to 3 PM) and it was rare to have only 9 residents. CNA #2 stated that the staff informed the Administrator during their meetings of the staffing ratios which was 8 residents during the day shift; 10 residents during the 3 PM to 11 PM (evening shift); and 15 residents on the 11 PM to 7 AM shift (night shift). On 08/27/24 at 11:36 AM, the surveyor interviewed the Director of Human Resources (DHR) who was responsible for the nursing schedule. She stated that the staffing ratio for the CNAs were 1:8 for the day shift; 1:10 for the evening shift; and 1:16 for the night shift. The DHR stated she did not always feel that the facility was meeting the staffing ratios due to call outs. She further stated that it was hard in the summer and on the weekends. The DHR stated that she was also a CNA and provided coverage on the weekends. She stated that she worked this	S 560		

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 08/30/2024

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) COMPLETE DATE
S 560	Continued From page 4 past weekend 8/24/24 and 8/25/24 and had 11 residents on the evening shift both days. The DHR stated that she was able to provide care to the residents because the staff worked together and assisted each other. She further stated that staff has not voiced their concerns about staffing to her. On 08/28/24 at 01:20 PM, the Regional Nurse/Vice President of Clinical (RN/VPC) stated in the presence of the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), the Infection Preventionist (IP), the Regional LNHA, the Regional of Social Services (RSS), and the survey team that the issue with staffing was due to the call outs. When asked are they meeting the staffing ratios? The (RN/VPC) stated, "Yes" they were meeting the staffing ratio but were struggling especially with the call outs. A review of the facility's Staffing policy, updated 1/2023, included, our facility provided sufficient numbers of staff in accordance with resident care plans and the facility assessment.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315362	A. Building B. Wing	9/25/2024

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 F0695 Reg. # 483.25(i) LSC	Correction Completed 09/19/2024	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
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

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	
8/30/2024	☐ 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		9/25/2024

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 09/19/2024	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
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

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	
8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/29/2024 and 08/30/2024 and Complete Care at Park Place was found to be in noncompliance 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. Complete Care at Park Place, LLC a one-story building that was built in 1997. It is composed of Type II protected construction. The facility is divided into six smoke zones. The generator does approximately 50% of the building as per the Maintenance Director. The current occupied beds were 86 of 94.	K 000		
K 222 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	K 222		9/16/24

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

Electronically Signed | 09/17/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 222	Continued From page 1 to the staff at all 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	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 222	Continued From page 2 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 REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 08/29/2024 and 08/30/2024 in the presence of facility management, it was determined that the facility failed to provide 4 of 10 designated exit access /discharge (illuminated exit signs above door) doors within the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with NFPA 101: 2012 Edition, Sections 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 and 7.2.1.6.1 (4). This deficient practice had the potential to affect 86 residents and was evidenced by the following: On 08/29/2024 during the survey entrance at approximately 9:07 AM, a request was made to the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility was a single-story building with 10 designated exit access/discharge doors (illuminated exit signs above doors) that resident, staff and visitors would use in the event of an emergency to exit the building. Observations starting at approximately 9:29 AM on 08/29/2024 and continued on 08/30/2024 in	K 222	Both sets of automatic double egress doors locking mechanisms were disabled and no longer function as locks. All residents may be affected by this incident. Maintenance staff were in serviced on 9/16/24 regarding egress doors that they should no have thumb locks on them. Egress doors will be audited weekly x4 monthly x3 by Maintenance director to ensure that they don't have thumb locking mechanism. The results of these audits will be reviewed by the quality assurance team who will make recommendations on the need for continued audits going forward.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 222	Continued From page 3 the presence of the [U.S. FOIA (b)] and [U.S. FOIA (b] revealed the following: 1) On 08/29/2024 at approximately 9:31 AM, the surveyor observed the main entrance (illuminated exit sign above the door) exterior double automatic front doors and interior double automatic doors. Observations revealed a thumb turn lock on both the egress sides of the two (2) doors. The two (2) thumb turn locks and fastening device on the doors could restrict emergency use of the designated exit discharge doors. A review of an emergency evacuation diagram posted in the corridor identified the front doors were the primary doors to reach an exit discharge door in the event of an emergency. 2) On 08/29/2024 at approximately 10:40 AM, the surveyor observed the two sets of double automatic designated exit access/discharge (illuminated exit sign above the door) exterior double automatic front doors and interior double automatic doors leading to the outside resident smoking area. Observations revealed a thumb turn locks on both the egress side of the two (2) doors. The two (2) thumb turn locks and fastening device on the doors could restrict emergency use of the designated exit discharge doors. A review of an emergency evacuation diagram posted in the corridor identify the front doors and smoking area doors were the primary routes to reach an exit discharge door in the event of an emergency. The [U.S. FOIA (b)] and [U.S. FOIA (] confirmed the findings at the times of observations.	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 222	Continued From page 4 The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (were informed of the deficient practice at the Life Safety Code exit conference on 08/30/2024 at approximately 10:35 AM.	K 222		
K 291 SS=F	NJAC 8:39-31.2 (e) Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/29/2024 and 08/30/2024 in the presence of facility management, it was determined that the facility failed to provide a functioning battery backup emergency lighting in 1 of 2 rooms for the two (2)emergency generator switch locations, independent of the building's electrical system and emergency generator in accordance with NFPA 101: 2012 Sections 7.9 and 19.2.9.1. This deficient practice had the potential to affect 86 residents and was evidenced by the following: In an interview on 08/29/2024 during the survey entrance at approximately 9:07 AM, the U.S. FOIA (stated they had a 200 KW (Kilowatt) Diesel Emergency Generator. Observations on 08/30/2024 at approximately 9:28 AM the presence of the U.S. FOIA (b) and U.S. FOIA (b) revealed there was no battery back-up emergency light for the "ASCO" generator transfer switch independent of the emergency	K 291	Emergency battery backup lighting was installed for generator transfer switch on 9/13/24. All residents may be affected by this incident. Maintenance staff were in serviced on 9/13/24 regarding battery backup lighting for transfer switch. Generator transfer switches will be audited weekly x4 monthly x3 by Maintenance director to ensure that is in place. The results of these audits will be reviewed by the quality assurance team who will make recommendations on the need for continued audits going forward.	9/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 291	Continued From page 5 generator. In an interview at the time, the U.S. FOIA (b) stated there was no emergency back-up emergency located in the area. The surveyor observed that the "ASCO" transfer switch indicator light was on and read Normal and Connected. The U.S. FOIA (b) and U.S. FOIA (confirmed the findings at the times of observations. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (were informed of the deficient practice at the Life Safety Code exit conference on 08/30/2024 at approximately 10:35 PM.	K 291		
K 324 SS=F	NJAC 8:39-31.2(e) Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4.	K 324		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 324	Continued From page 6 Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation on 08/29/2024 and 08/30/2024 in the presence of facility management, it was determined that the facility failed to inspect the kitchen range-hood fire suppression system semi-annually (every six months) in accordance with NFPA 96. This deficient practice had the potential to affect 86 Residents and was evidenced by the following: On 08/29/2024 during the survey entrance at approximately 9:07 AM, a request was made to the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) to provide all mandatory inspections from the last Recertification survey of 12/07/2022 through to 08/28/2024. At approximately 12:10 PM, a review of the facility's range-hood fire suppression system inspections for the previous 20 months identified the system had three (3) semi-annual inspections on the following dates: Contracted Kitchen Fire Suppression Vendor #1 reports:	K 324	Suppression hood system was inspected 7/31/24. All residents may be affected by this incident. Maintenance staff were in serviced on 9/16/24 regarding suppression hood system should be inspected semi annual. Suppression hood system will be audited weekly x4 monthly x3 by Maintenance director to ensure that inspections are with in proper inspection requirements The results of these audits will be reviewed by the Quality Assurance Team who will make recommendations on the need for continued audits going forward.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 324	Continued From page 7 - May 20, 2023 and November 09, 2023. Contracted Kitchen Fire Suppression Vendor #2 report: - July 31, 2024. In an interview on 08/30/2024 at approximately 8:20 AM, the U.S. FOIA (b) stated the facility was in-between Contracted Vendors at the time and there were no other inspection reports. The facility did not inspect the kitchen suppression system for the 8 months between November 9, 2023 and July 31, 2024. The U.S. FOIA (b) and U.S. FOIA (confirmed the findings at the times of review. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (were informed of the deficient practice at the Life Safety Code exit practice on 08/30/2024 at approximately 10:35 AM. NJAC 8:39-31.2(e) NFPA 96	K 324		
K 351 SS=F	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 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	K 351		9/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 351	Continued From page 8 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 on 08/29/2024 and 08/30/2024 in the presence of facility management it was determined that the facility failed to install sprinklers as required by CMS regulation §483.90(a) physical environment to all areas in accordance with NFPA 101: 2012 Edition, Sections 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2010 Edition. This deficient practice had the potential to affect 86 residents and was evidenced by the following: Observations on 08/29/2024 at approximately 9:55 AM in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), revealed inside the Commercial Laundry room above the two (2) Commercial Dryers, that one 2-foot by 2-foot ceiling tile was missing from the drop ceiling grid allowing heat to bypass the fire sprinkler head in the area and not activate the fire sprinkler system. The U.S. FOIA (b) and U.S. FOIA (confirmed the findings at the time of observation. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (were	K 351	Missing 2x2 ceiling in laundry room was installed on 9/2/24. All the residents may be affected by this incident. Maintenance conducted a facility wide inspection to ensure no additional ceiling tiles were missing. Maintenance Staff were in serviced on 9/11/24 that missing ceiling tiles may affect the sprinkler system. Ceiling tiles will be audited weekly x4 monthly x3 by Maintenance director to ensure that there is no missing ceiling tiles The results of these audits will be reviewed by the Quality Assurance Team who will make recommendations on the need for continued audits going forward.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 351	Continued From page 9 informed of the deficient practice at the Life Safety Code exit conference on 08/30/2024 at approximately 10:35 AM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 353 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 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 REQUIREMENT is not met as evidenced by: Based on interview and record review on 08/29/20024 and 08/30/2024 in the presence of facility management, it was determined that the facility failed to conduct Quarterly inspections of the automatic fire sprinkler system in accordance with NFPA 25. This deficient practice had the potential to affect	K 353	Sprinkler system was last inspected 8/7/24. All the residents may be affected by this incident. Maintenance staff were in serviced on	9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 353	Continued From page 10 86 residents and was evidenced by the following: On 08/29/2024 during the survey entrance at approximately 9:07 AM, a request was made to the U.S. FOIA (b) (6) U.S. FOIA (b) (6) and U.S. FOIA (b) (6) to provide all mandatory inspections from the last Recertification survey of 12/07/2022 through to 08/28/2024. At approximately 12:10 PM, a review of the facility's Quarterly (every 3 months)Fire Sprinkler System inspections for the previous 20 months identified the system had six (6) quarterly inspections on the following dates: Contracted Fire Sprinkler Suppression Vendor, - 01/31/2023, 04/27/2023, 07/26/2023, 10/18/2023, 01/26/2024 and 08/07/2024. In an interview on 08/30/2024 at approximately 8:20 AM, the U.S. FOIA (b) stated the facility was in-between Contracted Vendors at the time and there were no other quarterly sprinkler inspection reports. The facility did not conduct a quarterly fire sprinkler system inspection between 01/26/2024 and 08/07/2024. The facility failed to conducted quarterly (every three months) sprinkler inspections for the year 2024. The U.S. FOIA (b) and U.S. FOIA (confirmed the findings at the times of review. The U.S. FOIA (b) (6) U.S. FOIA (b) and U.S. FOIA (of the deficient practice at the Life Safety Code exit conference on 08/30/2024 at approximately 10:35 AM.	K 353	9/16/24 regarding sprinkler system should be inspected quarterly. Sprinkler system will be audited weekly x4 monthly x3 by Maintenance director to ensure that inspection are with in proper inspection Requirements The results of these audits will be reviewed by the quality assurance team who will make recommendations on the need for continued audits going forward.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 353	Continued From page 11 NJAC 8:39-31.2(e) NFPA 25	K 353		
K 355 SS=F	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 REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 08/29/2024 and 08/30/2024 in the presence of facility management, it was determined that the facility failed to perform a monthly examination for 14 of 14 portable fire extinguishers observed in accordance with NFPA 101: 2012 Edition, Sections 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10: 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. This deficient practice had the potential to affect 86 residents and was evidenced by the following: Observations starting at approximately 9:29 AM in the presence of the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) , revealed fourteen (14) portable fire extinguishers that were last annually inspected in November 2023 with no evidence of a monthly visual examination being performed and documented on the tags attached to the following fire extinguishers:	K 355	All fire extinguishers were last inspected September 2024. All the residents may be affected by this incident. Maintenance staff were in serviced on 9/11/24 regarding fire extinguishers should be inspected monthly. Fire extinguisher will be audited monthly x3 by Maintenance director to ensure fire extinguisher are up to date The results of these audits will be reviewed by the quality assurance team who will make recommendations on the need for continued audits going forward.	9/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 355	Continued From page 12 Facility identification numbers: #14, #13, #16, #11, #12, #10, #6, #9, #7, #2, #13, #18, #4 and #5. The [redacted] and [redacted] confirmed the findings at the time of observation. The [redacted] and [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 08/30/2024 at approximately 10:35 AM. NJAC 8:39 -31.1 (c), 31.2 (e). NFPA 10	K 355		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918		9/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 918	Continued From page 13 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 08/29/2024 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generators was installed in accordance with the requirements of NFPA 110: 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice had the potential to affect 86 residents and was evidenced by the following: In an interview on 08/29/2024 during the survey entrance at approximately 9:07 AM, a request was made to the U.S. FOIA (b) (6) U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) if the facility had an Emergency Generator. The U.S. FOIA (stated they had a 200 KW (Kilowatt) Diesel Emergency Generator. Observations starting at approximately 10:04 AM in the presence of the U.S. FOIA (b) and U.S. FOIA (b revealed that the 200 KW Diesel Emergency Generator had the Emergency Stop button located inside the	K 918	Generator remote emergency stop was installed on 9/16/24. All the residents may be affected by this incident. Maintenance staff were in serviced on 9/11/24 regarding remote emergency stop for generator. remote emergency stop will be audited weekly x4 monthly x3 by maintenance director to ensure that remote emergency stop is in place The results of these audits will be reviewed by the quality assurance team who will make recommendations on the need for continued audits going forward.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315362	A. BUILDING **01** B. WING _____	**08/30/2024**

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
K 918	Continued From page 14 metal housing of the generator on the control panel. There was no remote Emergency Stop button for the 200 KW Diesel Emergency Generator. In an interview at the time, the U.S. FOIA (stated there was no remote emergency stop for the generator. The U.S. FOIA (b) (and U.S. FOIA (confirmed the findings at the time of observation. The U.S. FOIA (b) (6) U.S. FOIA (b) (and U.S. FOIA (were informed of the deficient practice at the Life Safety Code exit conference on 08/30/2024 at approximately 10:35 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110	K 918		

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
315362 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/25/2024 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0222	09/16/2024	LSC K0291	09/13/2024	LSC K0324	09/16/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	09/11/2024	LSC K0353	09/16/2024	LSC K0355	09/12/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	09/16/2024	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	

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	
8/30/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO