STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 Survey Date: 2/22/23 Census:88 Sample: 18 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by:	F 637		2/20/23

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

Electronically Signed | 03/12/2023

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
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 637	Continued From page 1 Based on observation, interview, and record review it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, for 1 of 21 (Resident # 77) residents reviewed. This deficient practice was evidenced by the following: According to the Resident Assessment Instrument Manual Version 3.0 of Centers for Medicaid and Medicare Services (CMS) guidelines, updated October 2019, a SCSA MDS is required within 14 days after the facility determines or should have determined that there has been a significant change in the resident's physical or mental condition, a SCSA/MDS must be completed. (For purpose of this section, a significant change is a decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related interventions, that has an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both.) On 2/6/23 at 11:42 AM, the surveyor observed Resident # 77 awake and seated in a Ex Order 26. 4B1 inside his/her room. The surveyor reviewed the electronic and paper medical record for Resident # 77. Review of the Admission Record revealed that the resident was admitted to the facility with diagnoses that included but were not limited to	F 637	Resident #77 1) The MDS Coordinator modified the assessment for significant change for improvment. 2) All the residents may be affected by this incident. 3) The Regional Clinical Nurse in-serviced the MDS Coordinator on Federal Regulation F-637. 4) The MDS Coordinator will audit all the scheduled required assessments monthly for 3 months then quarterly. The DON will report the audit 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
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 637	Continued From page 2 Ex Order 26. 4B1 [redacted].	F 637		

Review of the quarterly MDS dated 9/9/22, revealed a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated that the resident had Ex Order 26. 4B1 [redacted]. The MDS also revealed that the resident's functional status for Ex Order 26. 4B1 required Ex Order 26. 4B1 with one person assistance, Ex Order 26. 4B1 required supervision with setup, and Ex Order 26. 4B1 required NJ Exec. Order 26:4.b.1 with one person assistance.

Review of the quarterly MDS dated 12/10/22, revealed a BIMS score of [redacted], which indicated that the resident had Ex Order 26. 4B1. The MDS also revealed that the resident's functional status for Ex Order 26. 4B1 improved. The MDS indicated the resident was NJ Exec. Order 26:4.b.1 t with Ex Order 26. 4B1 requiring setup assistance. The resident improved with eating independently requiring setup assistance. The MDS further revealed that the resident's NJ Exec. Order 26:4.b.1 also improved requiring supervision with setup assistance.

A review of the Ex Order 26. 4B1 [redacted] (OT) Plan of Care dated 11/22/22, revealed the resident began receiving OT services on 11/22/22. Review of the OT long-term goal plan was for the resident to complete Ex Order 26. 4B1 safely with supervision and that the resident will be able to perform [redacted] with supervision.

On 2/14/23 at 10:53 AM, the surveyor discussed with the Registered Nurse Minimum Data Set (RN/MDS) Coordinator, Resident # 77's Ex Order 26. 4B1 [redacted] and three areas in the functional status, Section G of the quarterly MDS dated 12/10/22. The RN/MDS Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 637	Continued From page 3	F 637		

acknowledged that the resident began [NJ Exec. Order 2] services on 11/22/22, to improve with his/her *Ex Order 26. 4B1* (ADLs). She stated that she didn't think the improvements in the functional status section of the 12/10/22 MDS required a significant change in status because the resident was expected to improve in his/her ADLs because of *Ex Order 26. 4B1* services. She further stated that that she did not discuss the resident's *Ex Order 26. 4B1* status changes with the Interdisciplinary Team.

Review of the Quarterly IDCP [Interdisciplinary Care Plan] meeting dated 12/20/22, indicated that the IDCP team met and discussed that the residents "needs are being met by staff" including his/her medical and *Ex Order 26. 4B1* "needs are monitored daily ...staff will continue to be supportive." There was no documented evidence that the team discussed the resident's improvement in *Ex Order 26. 4B1* and in his/her *Ex Order 26. 4B1* status.

Review of the resident's care plan with a focus area for at risk for ADL decline due to *Ex Order 26. 4B1* dated 11/23/22, indicated a goal to show improvement in mobility status and in ADLs.

On 2/14/23 at 2:00 PM, the surveyor discussed the above findings with the Licensed Nursing Home Administrator and the Director of Nursing.

On 2/15/23 at 12:40 PM, the survey team met with the facility administration team who acknowledged that a significant change in status for Resident # 77 should have been completed.

Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 637	Continued From page 4 Version 1.17.1, October 2019, reflected on page 2-18 that a SCSA MDS must be completed "no later than" the 14th calendar day after determination that a significant change in resident's status occurred. The manual further reflected on page 2-22 that "A significant change is a major decline or improvement in a resident's status." There was no additional information provided.	F 637		
F 658 SS=E	NJAC 8:39-11.2(i) Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to follow a physician's order for *Ex Order 26. 4B1* [redacted] levels in the blood every three months for Resident #47. This deficient practice was identified for 1 of 21 residents reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states:	F 658	Resident #47 1) The physician was immediately notified the physician and the [redacted] level was drawn and within normal level. The Physician ordered to discontinue the standing order of [redacted] level. The DON reviewed and updated the resident's care plan for comfort care including the continued use of [redacted] without the [redacted] level. 2) All residents may be affected by this practice.	2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 658	Continued From page 5 "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 2/8/23 at 11:45 AM, the surveyor observed Resident #47 lying in bed awake, was NJ Exec. Order 26:4.b.1 [redacted], and was NJ Exec. Order 26:4.b.1 [redacted] with the surveyor. The surveyor reviewed the medical records of Resident #47. Review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, but not limited to Ex Order 26. 4B1 [redacted],	F 658	3) The DON will in-service the 11-7 shift supervisor and/or designee on how to track the laboratory test standing orders. The Pharmacy Consultant will include the standing order lab evaluation in r/t medication use on his/her monthly medication review report. The Regional Nurse Consultant will in-service the nurses, unit managers, DON, IP and MDS Coordinator on how to create a person centered care plans, measurable goals, update and evaluation of the interventions. The Unit Managers and/or designee will evaluate and update the care plan in r/t significant changed in the plan of care of the resident. 4) The 11-7 Shift Supervisor will audit 5 standing order of labs monthly for 3 months and then quarterly. The MDS Coordinator will audit the care plan of the resident due for the required assessment monthly for 3 months and then quarterly. The DON will report the audit 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
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 658	Continued From page 6	F 658		

Ex Order 26. 4B1 [redacted].

Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/20/22, indicated that the resident's cognitive skills for daily decision making was *Ex Order 26. 4B1* [redacted].

Review of the Attending Physician's (AP's) Doctor's Progress Notes dated 10/8/22, included a diagnosis of *Ex Order 26. 4B1* [redacted].

Review of the Physician's Order (PO) dated 4/2/22, reflected a PO for *Ex Order 26. 4B1* [redacted] via *Ex Order 26. 4B1* [redacted] one time a day in the morning and *Ex Order 26. 4B1* [redacted] via *Ex Order 26. 4B1* [redacted] in the evening.

Review of the April 2022 through February 2023, Medication Administration Records (MARs) reflected the above corresponding PO's.

Further review of the February 2023 POs included a PO for *Ex Order 26. 4B1* [redacted] levels every three months, dated 8/26/20.

Review of the hybrid (paper and electronic) medical records for Resident # 47 revealed that the last *Ex Order 26. 4B1* [redacted] level was obtained on 4/15/22.

There was no documented evidence in the resident's medical records that *Ex Order 26. 4B1* [redacted] levels were obtained after 4/15/22 in accordance with the PO.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 658	Continued From page 7 Review of the resident's comprehensive care plans reflected a focus area for Ex Order 26. 4B1 [redacted] effective on 9/6/22. Interventions dated 9/6/22, included to "monitor drug treatment and dosage adjustments to minimize adverse reaction to other medications." On 2/8/23 at 12:12 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who acknowledged that the last Ex Order 26. 4B1 [redacted] level was obtained on 4/15/22, and should have been obtained again in July 2022, October 2022 and January 2023. The RN/UM could not speak to why the Ex Order 26. 4B1 [redacted] levels were not done. On 2/9/23 at 9:42 AM, the surveyor, in the presence of the survey team informed the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) of the above concerns. The DON stated that she would review the resident's medical records and would get back to the surveyor. On 2/13/23 at 9:19 AM, during a follow up interview with the DON and LNHA in the presence of the survey team, the DON acknowledged that there were no Ex Order 26. 4B1 [redacted] levels obtained after 4/15/22. She stated that the Ex Order 26. 4B1 [redacted] levels were "missed" and "have fallen through the cracks." On 2/16/23 at 11:47 AM, the survey team met with the LNHA, Regional Registered Nurse (RRN#1), RRN#2, DON, and the Infection Control Preventionist Nurse (ICPN). There was no additional information provided. Review of the facility policy "HMNR Laboratory,	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 658	Continued From page 8 Radiology And Other Diagnostic Services" last revised on April 2021 and effective on 4/2022, included that the "Purpose" was "To ensure that laboratory, radiology, and other diagnostic services meet the needs of resident/patients. To ensure that results are reported promptly to the ordering practitioner to address disease prevention, potential concerns, and/or provide for resident/patient assessment, diagnosis and treatment." In addition, it included "The nurse will ensure that arrangements are made for laboratory or diagnostic services when ordered by a physician, covering physician, consultant or nurse practitioner."	F 658		
F 692 SS=G	NJAC 8:39-11.2(b) Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;	F 692		3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 692	Continued From page 9 §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to a.) identify and address multiple severe weight losses and consistently obtain reweights, b.) implement and monitor weekly weights, c.) evaluate and adjust nutritional interventions, e.) comprehensively assess the resident after a significant weight change and f.) revise the nutritional care plan. This was identified for 1 of 5 residents (Resident #47) reviewed for nutrition. The evidence was as follows: 1. On 2/8/23 at 11:45 AM, the surveyor observed Resident #47 lying in bed awake. The resident appeared thin, was Ex.Order 26.4(b)(1) [redacted] with the surveyor. The surveyor reviewed the medical records of Resident #47. Review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, but not limited to unspecified *Ex Order 26. 4B1* [redacted]	F 692	Resident #47 1) The Director of Nursing notified the physician immediately in reference to the resident's significant *Ex Order 26. 4B1*. The physician ordered to change the *Ex Order 26. 4B1* via the *Ex Order 26. 4B1* to continuous feeding. The physician ordered the *Ex Order 26. 4B1* [redacted] feeding of *Ex Order 26. 4B1* to run at *Ex Ord* [redacted] per hour for 16 hours for the next 3 days then increase the rate to *Ex Order 26. 4B1* per hour for 16 hours thereafter. The physician ordered the weekly weights and refer the resident to the dietician for evaluation. The physician ordered to maintain the resident as comfort care. 2) All the residents may be affected by this practice. 3) The Regional Nurse Consultant will in-service the Registered Dietician on Federal Regulation F 692. The Director of Nursing will in-service the Unit Managerss, Supervisors, and Nurses on Federal Regulation F 692. The Administrator hired a new Registred Dietician under MNT group to start 2/28/23. The Director of Nursing will in-service the newly hired dietician on Federal Regualtion F692.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 692	Continued From page 10 diseases classified elsewhere, unspecified severity, with Ex.Order 26.4(b)(1) . Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 8/20/22 and 11/20/22, indicated that the resident's cognitive skills for daily decision making was Ex Order 26. 4B1 with Ex.Order 26.4(b)(1) A further review of the resident's MDS, Section K - Swallowing/Nutritional Status revealed that the resident had a Ex Order 26. 4B1 and significant Ex Order 26. 4B1 that was not prescribed by the physician. Review of the Physician's Order (PO) dated 6/11/20, reflected that the resident had an PO for the Ex Order 26. 4B1 formula of Ex Order 26. 4B1 - one can Ex Order 26. 4B1 via Ex Order 26. 4B1 four times daily at 9AM, 1 PM, 5 PM, and 9 PM for a total volume of 948 mL. Review of the July 2022 through February 2023, Medication Administration Record (MAR) reflected the above corresponding PO's. Review of the resident's Monthly Record of V/S (vital signs) and Weights reflected the following weights: March 2022 Ex.Order 26.4(b) lbs. April 2022 Ex.Order 2 lbs. May 2022 Ex.Order 26.4 lbs. June 2022 Ex.Order 26.4 lbs. July 2022 Ex.Order 26.4 lbs.	F 692	The Registered Dietician will review the weekly weights of the residents weekly. The Registered Dietician will update the care plan of the resident related to nutritional and weight problem. The Unit Manager and or charge nurses will notify the physician and or Nurse Practitioner of any significant weight loss or weight gain. 4) The Registered Dietician or Director of Nursing will audit 6 residents with significant Ex Order 26. 4B1 or Ex Order 26. 4B1 monthly and then quarterly. The Registered Dietician will audit 5 plan of care of the residents related to nutritional and weight problem monthly for 3 months. The Director of Nursing will the audit report to the Quality Assurance Improvment Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 692	Continued From page 11	F 692		

August 2022 Ex.Order 2 lbs. reweighed at Ex.Orde 4 lb. Ex.Order 26.4(pound (lb.) and Ex.Order 26.4(b)(1) over one month

September 2022 Ex.Order 2 lbs. - Ex.Order 26.4(b)(. and Ex.Order 26.4(b)(Ex.Order 26 over 6 months

October 2022 Ex.Order 26.4(b)(1) . - Ex.Order 26. lb. and Ex.Order 26.4(b)(1) over 6 months

November 2022 Ex.Order 2 lbs. Ex.Order 26.4(lb. and Ex.Order 26.4(b) loss over 6 months

December 2022 Ex.Orde lbs. Ex.Order 26.4(lb. and Ex.Order 26.4(b)(1) over 6 months

January 2023 Ex.Order 26.(lbs. Ex.Order 26 lb. and Ex.Order 26.4(b)(1) over one month

Review of the resident's progress notes from the hybrid (both paper chart and electronic medical records) medical record from July 6, 2022, through February 5, 2023, included the following documentation related to *Ex Order 26. 4B1*:

The Quarterly Nutritional Assessment (NA) completed by the Registered Dietitian (RD), dated 8/23/22, indicated that the resident had Ex.Order 26.4(b)(1) " in the past 6 months ... "Will suggest to Ex.Order 26.4(b)(1) resident and will check the reliability of the Ex.Order 26.4 used." The RD also indicated that she would follow up.

The Quarterly NA completed by the RD, dated 2/5/23, indicated that the resident had "significant *Ex Order 26. 4B1* in the past 2 quarters ..." She also indicated that the resident was on '*Ex Order 26. 4B1* . Gets 4 cans of *Ex Order 26. 4B1* = gives 1420 calories and 60.4 grams protein. Resident gets

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 692	Continued From page 12 105% of the required calories ...no recent laboratory reports are available except HBG and HCT which Ex.Order 26.4(b)(1). Will continue to follow up." Review of the Quarterly IDCP (Interdisciplinary) care plan meetings dated 8/30/22 and 11/29/22 did not include documented evidence that the team was aware that the resident experienced significant *Ex Order 26. 4B1*. Review of the Nurses Progress notes did not include documented evidence that nursing was aware that the resident experienced significant *Ex Order 26. 4B1*. Review of the resident's Attending Physician (AP) Doctor's Progress Notes dated 10/8/22, 1/17/23, and 2/5/23 did not include documented evidence that the AP was aware of the resident experienced significant *Ex Order 26. 4B1*. Review of the resident's comprehensive care plan including the following focused areas: 1. The Nutrition- *Ex Order 26. 4B1* comprehensive care plan with an effective date of 3/1/22. 2. The *Ex Order 26. 4B1* comprehensive care plan with an effective date of 3/1/22. 3. The Nutrition- Risk for *Ex Order 26. 4B1* Ex.Order 26 with an effective date of 5/25/22. All three comprehensive focused care plan areas did not include documented evidence of the resident's significant *Ex Order 26. 4B1*. Further review of the *Ex Order 26. 4B1* comprehensive care plan with an effective date of 3/1/22, indicated that the Goals "will receive	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 692	Continued From page 13 adequate Ex.Order 26.4(b)(1) via Ex Order 26. 4 with good tolerance over the next three months." It also indicated interventions to "follow up Ex.Order 26.4(b)(1) On 2/9/23 at 9:42 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The DON stated that the residents were weighed monthly by the Certified Nursing Aide (CNA)'s. She also stated that the CNAs would verbally communicate the weights to the nurses. She then stated that the nurses would document the weights in the Monthly Record of V/S and Weights form in the resident's paper chart in the Dietary section. During the interview, the DON informed the survey team that the resident would be reweighed if there was a weight discrepancy such as significant Ex Order 26. 4B1. She also stated that when a resident's Ex Order 26. 4B1 was confirmed, the nurse would notify the resident's AP of the resident's Ex Order 26. 4B1. The DON stated that a dietary consult was "usually a physician's order." She also stated that if the AP ordered a dietary consult, the nurses would verbally communicate this to the RD. On 2/14/23 at 12:32 PM, the surveyor interviewed the assigned CNA for Resident #47. She stated that the CNAs were responsible for weighing "all" the residents once a month, by the fifth of the month. She further stated that the nurses assigned the CNAs the residents who needed to be weighed and the CNA's would verbally communicate the residents' weights to the nurse, or would write it on the daily assignment sheets.	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 692	Continued From page 14 The CNA stated that she was not aware that Resident #47 had [redacted].	F 692		

On 2/14/23 at 12:46 PM, the survey team interviewed the RD in the presence of the LNHA. The RD informed the survey team that the residents' weights were taken by the nursing staff every first week of the month. She stated that the Unit Manager (UM) nurse would report to her which residents had a [redacted] of 5 lbs. or more and stated, "I have continuous communication with nursing about residents that have [redacted]."

During the interview, the RD stated that when a resident had a significant [redacted], they would do a 3-day calorie count to determine if the resident's intake was meeting his/her needs and stated, "we always do that." She further stated that she would discuss the calorie count results that were kept in the resident chart with the nurse, and she would explain how the results were related to the [redacted], which were documented in the medical record.

On that same date and time, the RD informed the survey team that they did not have weight meetings. She stated that she would make recommendations and that there would be continuous follow up for any significant [redacted]. She further stated that they would evaluate the residents on a quarterly basis whether there was an improvement or not. In addition, she stated that she reviewed the residents' weights monthly, reviewed the [redacted] trends, and that she would follow up every month to ensure that the interventions were effective. She stated, "weight is the most significant, sensitive yardstick of nutritional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 692	Continued From page 15 assessment of the patient." The RD stated that if a resident experienced a significant Ex Order 26. 4B1, monitoring weekly weights for four weeks would be warranted. She further stated that she would recommend to start a Ex.Order 26.4(b)(1) and weekly weights by communicating to the nurses and the AP. On 2/15/23 at 10:28 AM, the surveyor interviewed the resident's AP in the presence of the survey team, who stated that she visited the resident every month. She also stated that after visiting the resident, she documented the encounter in the resident's paper medical records. During the interview, she acknowledged that she noticed "a lot of Ex Order 26. 4B1" for Resident #47. The AP acknowledged that she had not increased the resident's Ex Order 26. 4B1 Ex.Order 26. formula order prior to the surveyor's inquiry. She further acknowledged that she could have increased the Ex.Order and stated, "I am not saying that I don't want to give her food." The AP could not verify when and who in the facility notified her that the resident had significant Ex Order 26. 4B1. The AP stated that if the resident had a significant Ex Order 26. 4B1, "I would have documented that in the medical record." . On 2/15/23 at 10:52 AM, the Unit Manager/Registered Nurse (UM/RN) stated that she would notify the resident's AP of a confirmed Ex Order 26. 4B1 and that the AP would order a dietary consult. In addition, she also stated that the notification of Ex Order 26. 4B1 and discussions had with the AP and RD should be documented in the resident's electronic medical records. She further stated that the RD would conduct her nutrition assessment and recommend a 3-day calorie count, and that she would notify the AP of the RD's recommendations. In addition, the UM/RN	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 692	Continued From page 16 stated that if a resident was not getting enough calories to maintain their weight, she would expect recommendations from the RD. During the interview with the UM/RN, who further stated that when she returned to work last month she was informed that Resident #47 had a "gradual" significant Ex Order 26. 4B1 over the last 6 months. She also stated that she did not notify the resident's AP regarding the resident's significant Ex Order 26. 4B1. On 2/15/23 at 12:42 PM, the LNHA, Regional RN#1 (RRN#1), DON, and MDS Coordinator met with the survey team. The RRN#1 confirmed that the RD did not have documented evidence in Resident #47's hybrid medical records to address the significant Ex Order 26. 4B1. She further confirmed that there was no documented evidence that the RD conducted follow-up assessments. During that same interview, the RRN#1 further stated that the AP acknowledged that she was aware of the resident's significant Ex Order 26. 4B1 but there was no documented evidence in the resident's hybrid medical record that the AP addressed Resident #47's significant Ex Order 26. 4B1 [redacted]. The RRN#1 stated, "that's a problem." On 2/16/23 at 11:05 AM, the LNHA, RRN#1, RRN#2, DON, and the Infection Control Preventionist Nurse (ICPN) met with the survey team. The RRN#1 acknowledged that the resident's Ex Order 26. 4 Ex.Ord [redacted] PO was "never changed since 2019 to the present," until surveyor inquiry. She further stated that the resident "suddenly, had a lot of Ex Order 26. 4B1 in one month," and was Ex.Order 26.4(b)(1) " and the AP "never" addressed the	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 692	Continued From page 17 significant Ex Order 26. 4B1 until after surveyor inquiry. She also acknowledged that resident's significant Ex Order 26. 4B1 were not addressed in the resident's comprehensive care plans. On 2/16/23 at 11:47 AM, the survey team met with the LNHA, RRN#1, RRN#2, DON, and ICPN. There was no additional information provided. Review of the facility policy "HMNR Role of the Registered Dietitian" dated 12/2022, included that the "Purpose" was "To ensure that the RD's are in adherence with rules and regulations set forth by the Centers for Medicare and Medicaid Services (CMS)." In addition, it included "Create a proper diet that fits all nutritional needs for residents/patients."; "Participate in interdisciplinary care planning."; and "Perform follow up assessment quarterly or more often if needed for long term care residents." Review of the facility policy "HMNR Registered Dietitian Documentation" dated 12/2022, included that the "Purpose" was " ...To ensure consistency in the documentation of nutrition care by Registered Dietitian's. To support and justify nutrition care. To document the results of nutrition care." In addition, it included the following: "Nutrition Assessment and Consultation - Evaluation of nutrition/medical history lab values, anthropometric (measurements and proportions of the human body, such as weight) measurements ... Action or recommendations with desired outcomes/measurable goal. To be entered in the [electronic medical record] under assessments ..."; "Follow-up Evaluation ... Effectiveness of nutritional intervention as it relates to goals. Monitor (review, measure status and timeliness), evaluate (compare with previous	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 692	Continued From page 18 status, intervention goals and reference standards, and document progress (using defined indicators) ... Re-assessment - Significant changes in lab values, anthropometric measurements, nutrient needs, ... Care plan ..." Review of the facility policy "HMNR Resident/Patient Weights" dated 7/2022, included that the "Purpose" was "To monitor the resident's/patient's nutritional status and appropriately respond to significant weight changes." In addition, it included the following: "Weight can be a useful indicator of nutritional status ...Weight goals should be based on a resident's/patient's usual body weight or desired body weight ... Resident/patient weights will be monitored over time to identify *Ex Order 26. 4B1*, verify weight measurements when changes in weight occur, and reassess weight interventions when appropriate ... Facility scales will be calibrated annually or more often as needed by the Maintenance director/supervisor ... Any resident/patient with a weight change of five (5) pounds or more will be re-weighed for accuracy ... Any resident/patient with a significant weight change will be referred to the Dietitian for assessment ... All resident/patient weights will be reviewed by nursing and dietary to determine significant change ... Residents/patients with a recent history of *Ex Order 26. 4B1* or risk for *Ex Order 26. 4B1* may be weighed weekly as determined by the dietitian and or physician ... Appropriate, individualized resident/patient interventions will be initiated to prevent and/or address significant unplanned weight changes ... Residents/patients identified with significant *Ex Order 26. 4B1* will be reviewed during nutrition rounds or facility weight meeting ... The Dietitian will document in the medical record any resident/patient weight	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 692	Continued From page 19 changes and interventions initiated, as well as in the care plan ... Nursing or designee will notify the physician and or family/representative of any significant resident/patient weight changes." Review of the facility policy "Tracking Weight Changes" with a revised date of 12/21, included "Weights will be documented for all individuals, for the purpose of assessing significant and gradual weight changes." In addition, it included the following: "The facility will be responsible for obtaining accurate weights on a regular basis, and for keeping accurate records ... A copy of the weight records will be forwarded to the appropriate professional each month: weight team leader, registered dietitian nutritionist (RDN) or designee, nursing supervisor, etc. The RDN or designee will review monthly weights and calculate significant change over one, three and six months ... A copy of all significant Ex Order 26. 4B1 [redacted] and gains will be given to the interdisciplinary care team for appropriate review and documentation ... All individuals with significant weight changes will be reweighed to assure accuracy of the weight prior to reporting to the staff, physician or family ... The care plan team will review and document on all ... significant weight changes, with appropriate referrals to the physician and RDN or designee. The RDN or designee will review all significant Ex Order 26. 4B1, ... will make referrals and take action as necessary (including follow up documentation). The individual, family (or representative), physician and RDN or designee will be notified of any individual with an unintended significant weight change of 5% in one month, 7.5% in three months, or 10% in six months ... Individuals with significant unintended weight changes will be added to weekly weights	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 692	Continued From page 20 for a minimum of 4 weeks or until weight stabilizes." Review of the facility policy "HMNR Care Plan" dated 12/2022, included that the "Purpose" was "To develop and implement a care plan for each resident/patient that includes the interventions needed to provide effective and person-centered ... care of the resident/patient that meet professional standards of quality care." In addition, it included the following: "The comprehensive care plan must describe ... The services that are to be furnished to attain or maintain the resident/patient highest practicable physical, mental, and Ex Order 26. 4B1 well-being." Furthermore, it included that the care plan should be "Prepared by an interdisciplinary Team, that includes but is not limited to - the attending physician or non-physician practitioner, a registered or licensed practical nurse ... a Registered Dietitian ..." The care plan should also be "Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive, significant change, quarterly, and annual review assessments." NJAC 8:39-11.2(e)(2) (i), 17.1(c), 17.4(a)(3), 27.1(a)	F 692		
F 710 SS=E	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse	F 710		3/17/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 710	Continued From page 21 specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure the physician a.) addressed multiple severe Ex Order 26. 4B1 , b.) implemented and monitored weekly weights, and c.) evaluated and adjusted Ex.Order 26.4(b)(1) for 1 of 5 residents (Resident #47) reviewed for Ex.Order 26.4(b)(1) The deficient practice was evidenced by the following: 1. On 2/8/23 at 11:45 AM, the surveyor observed Resident #47 lying in bed awake. The resident appeared Ex.Order 26 was Ex.Order 26.4(b)(1) and was Ex.Order 26.4(b)(1) with the surveyor. The surveyor reviewed the medical records of Resident #47. Review of the Resident Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included, but not limited to Ex Order 26. 4B1	F 710	Resident#47 1) The Director of Nursing notified the resident's physician immediately in reference to Ex Order significant Ex Order 26. 4B1. The physician changed the Ex Order 26. 4B1 of Ex Order 26. 4B1 to continuous feeding via Ex Order 26. 4B. The physician ordered to increased the Ex Order 26. 4B1 of Ex Order 26. 4B1 to Ex Order 26. 4B1 per hour for 16 hours per 24 hour with the total voloume of Ex Order 26. 4B1 per 24 hours as tolerated for 72 hours. Then increase the Ex Order 26. 4B1 per hour for 16 hours per 24 hours with the total volume of Ex Order 26. 4B1 per 24 hours thereafter. The physician ordered weekly weights. The physician ordered to maintain the resident under comfort care. The Director of Nursing updated the care plan. 2) All the residents may be affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 710	Continued From page 22 Ex Order 26. 4B1 [redacted]. Review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 8/20/22 and 11/20/22, indicated that the resident's Ex Order 26. 4B1 for daily decision making was Ex Order 26. 4B1 with total dependence of Ex.Order 26.4(b)(1) [redacted]. A further review of the resident's MDS, Section K - Swallowing/Nutritional Status revealed that the resident had a Ex Order 26. 4B1 and significant Ex Order 26. 4B1 that was not prescribed by the physician. Review of the Physician's Order (PO) dated 6/11/20, reflected that the resident had an PO for the Ex Order 26. 4B1 formula of Ex Order 26. 4B1 - one can Ex Order 26. 4B1 via Ex Order 26. 4B1 four times daily at 9AM, 1 PM, 5 PM, and 9 PM for a total volume of Ex Order 26. 4B1. Review of the July 2022 through February 2023, Medication Administration Record (MAR) reflected the above corresponding PO's. Review of the resident's Monthly Record of V/S (vital signs) and Weights reflected the following weights: March 2022 Ex.Order 26.4 lbs.	F 710	3) The Director of Nursing will-inservice all the nurses to notify the physician or Nurse Practitioner on Federal Regulation F 710. The Director of Nursing and Facility Educator will in-service the nures on Federal Regulation F 710. The Physician will refer the resident with significant Ex Order 26. 4B1 and Ex Order 26. 4B1 to the significant weight loss or Ex Order 26. 4B1 to the dietician. The Reistered Dietician will review and update the plan of care of the resident if necessary. The Director of Nursing and the Administrator will in-service the physicians and NP to review the resident's weight and address it in the progress notes. 4) The Director of Nursng will audit 6 residents in r/t residents with significant Ex Order 26. 4B1 or Ex Order 26. 4B1 and physican was notified monthly and then quarterly. The Director of Nursing will audit 5 resident's care plan for nutritional and weight problems monthly for 3 months then querterly The 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
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 710	Continued From page 23 April 2022 Ex.Order [redacted] lbs. May 2022 Ex.Order 26.4 [redacted] lbs. June 2022 Ex.Order 26.4 [redacted] lbs. July 2022 Ex.Order 26.4 [redacted] lbs. August 2022 Ex.Order [redacted] lbs. reweighed at Ex.Order 26.4(b)(1) pound (lb.) and Ex.Order 26.4(b) [redacted] loss over one month September 2022 Ex.Order 26.4(b)(1) lb. and Ex.Order 26.4(b) [redacted] Ex.Order [redacted] over 6 months October 2022 Ex.Order 26.4(b) [redacted] lbs. Ex.Order 26.4(b)(1) % Ex.Order [redacted] over 6 months November 2022 Ex.Order 26. [redacted] lbs. Ex.Order 26.4(b)(1) % Ex.Order [redacted] over 6 months December 2022 Ex.Order 26.4(b)(1) lb. and Ex.Order 26.4(b)(1) over 6 months January 2023 Ex.Order 26.4(b)(1) [redacted]. Ex.Order 26.4(b)(1) [redacted] over one month Review of the resident's Attending Physician (AP) Doctor's Progress Notes dated 10/8/22, 1/17/23, and 2/5/23 did not include documented evidence that the AP was aware of the resident experienced significant *Ex Order 26. 4B1* [redacted]. On 2/15/23 at 10:28 AM, the surveyor interviewed the resident's AP in the presence of the survey team, who stated that she visited the resident every month. She also stated that after visiting the resident, she documented the encounter in the resident's paper medical records. During the interview, she acknowledged that she noticed "a	F 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 710	Continued From page 24 lot of Ex.Order 26.4(b)(1)" for Resident #47. The AP acknowledged that she had not increased the resident's Ex Order 26. 4B1 Ex.Order 2 formula order prior to the surveyor's inquiry. She further acknowledged that she could have increased the Ex.Order and stated, "I am not saying that I don't want to give her food." The AP could not verify when and who in the facility notified her that the resident had significant Ex Order 26. 4B1. The AP stated that if the resident had a significant Ex Order 26. 4B1, "I would have documented that in the medical record." On 2/15/23 at 12:42 PM, the LNHA, Regional RN#1 (RRN#1), DON, and MDS Coordinator met with the survey team. RRN#1 stated that the AP acknowledged that she was aware of the resident's significant Ex Order 26. 4B1, but there was no documented evidence in the resident's hybrid (electronic and paper) medical record that the AP addressed Resident #47's significant Ex Order 26. 4B1 [redacted]. The RRN#1 stated, "that's a problem." On 2/16/23 at 11:05 AM, the LNHA, RRN#1, RRN#2, DON, and the Infection Control Preventionist Nurse (ICPN) met with the survey team. The RRN#1 acknowledged that the resident's Ex Order 26. 4 Ex.Order PO was "never changed since 2019 to the present," until surveyor inquiry. She further stated that the resident "suddenly, had a lot of Ex Order 26. 4B1 in one month," and was Ex.Order 26.4(b)(1)" and the AP "never" addressed the significant Ex Order 26. 4B1 in the medical record until after the surveyor inquiry. On 2/16/23 at 11:47 AM, the survey team met with the LNHA, RRN#1, RRN#2, DON, and ICPN. There was no additional information provided.	F 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 710	Continued From page 25 NJAC 8:39-23.2 (b)	F 710		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 3 of 4 medication carts inspected. This deficient practice was evidenced by the following:	F 761	1) The following medications were removed and disposed and ordered a replacement: a. Xalatan eye drops b. Timolol eye drops c. Dorzolamide eye drops d. Glucose test strips	2/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 761	Continued From page 26 On 2/13/23 at 10:30 AM, the surveyor inspected the [redacted] high end medication in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an unopened and undated bottle of [redacted] eye drops [redacted] that was stored inside the medication cart. The surveyor also observed an opened bottle of [redacted] eye drops [redacted] that was undated (pharmacy label date 2/5/23) and an opened bottle of [redacted] eye drops [redacted] that was opened with an opened date of 1/6/23, and was expired. The surveyor interviewed LPN #1 who stated that an unopened bottle of [redacted] eye drops should have been stored inside the medication refrigerator because once opened or once stored at room temperature, the medication will have a 42-day expiration date. LPN #1 also acknowledge that an opened bottle of [redacted] eye drops should have been dated because once opened, it only had a 28-day expiration date. LPN #1 further stated that the [redacted] eye drops that was opened and dated 1/6/23, was expired and should have been removed from the medication cart. On 2/13/23 at 11:30 AM, the surveyor inspected the [redacted] low-side medication Cart in the presence of LPN #2. The surveyor observed an opened bottle of [redacted] that was not dated. The surveyor also observed an opened bottle of [redacted] eye drops [redacted] that was dated 12/28/22, and was expired. The surveyor interviewed LPN #2 who stated that an opened bottle of [redacted] should	F 761	e. [redacted] eye drops The Director of Nursing assessed the residents who used the [redacted] eye drops, [redacted] eye drops, [redacted] eye drops, and [redacted] eye drops and no adverse effect noted. The physicians responsible for the care of the residents were notified and received no new order. 2) All the residents may be affected by this practice. 3) The Director of Nursing and facility educator will in-service all the nurses on Federal Regulation F761 in r/t medications and biologicals storage and labeling. The Charge Nurse or a floor nurse will check their own assigned medication and treatment carts daily in reference to storage, labeling, and expiration date of the drugs and biologicals. 4) The 11-7 Supervisor will audit 2 medication carts and 2 medication refrigerators weekly x 4 weeks then monthly x 3 months then quarterly. The DON will report the audit 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
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 761	Continued From page 27 have been dated. LPN #2 also acknowledge that the Ex Order 26. 4B1 eye drops were expired and should have been removed from the medication cart. On 2/13/23 at 11:00 AM, the surveyor inspected the Ex Order 26. 4B1 high-side medication cart in the presence of a Registered Nurse (RN#1). The surveyor observed a bottle of Ex Order 26. 4B1 eye drops that had an opened date of 1/25/23, but had no label containing a resident's name. They was no corresponding bag or box for the Ex Order 26. 4B1 eye drops. The surveyor interviewed RN#1 who stated that all the medication inside a medication cart or a medication refrigerator should have the name of a resident. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. Unopened Ex Order 26. 4B1 eye drops should have been stored in a refrigerator. 2. Ex Order 26. 4B1 eye drops once stored at room temperature have an expiration date of 42-days 3. Ex Order 26. 4B1 eye drops once opened have an expiration date of 28-days 4. Ex Order 26. 4B1 eye drops once opened have an expiration date of 28-days 5. Ex Order 26. 4B1 eye drops once opened have an expiration date of 28-days. 6. Ex Order 26. 4B1 once opened have an expiration date of 90-days. On 2/14/23 at 1:35 PM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) and discussed the above observations and findings. No further information was provided by the facility.	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 761	Continued From page 28 A review of the facility's policy for Medication Storage dated 3/2022, provided by the LNHA indicated the following: "6. Expired, discontinued and /or contaminated medications will be removed from the medication storage areas and disposed of in accordance with facility policy" "8. Medications will be stored at the appropriate temperatures in accordance with the pharmacy/or manufacturer labeling." "9. Medications requiring refrigeration will be stored in a refrigerator that is maintained between 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit)." A review of the facility's policy for Medication Labeling and Dating that was dated 3/2022 and was provided by the LNHA indicated the following: "3. The label for each resident's individual medication container or package shall include at least the following: a. The resident's full name." "Medication Dating: 1. The expiration date for all medications will be labeled expiration date unless the manufacturer gives specific requirements for "beyond use dates". 2. "Beyond use dates" refer to a specific amount of a time a medication is still able to be used once it has been removed from the manufacturer's specified storage conditions (e.g., opened vial or	F 761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE PLAINFIELD, NJ 07060**

(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 761	Continued From page 29 package, removed from refrigeration). a. Once a medication has been removed from the manufacturer's specified storage conditions, the medication will be dated with the current date." b. When the medication reaches its beyond-use-date, based on the date it was opened or removed from the manufacturer's specified storage conditions, it will be discarded according to the facility policy. c. The beyond use date cannot exceed the manufacturer's expiration date. d. Medications requiring specific dating upon opening are typically labeled with cautionary and/or accessory labels alerting the nurse to this dating recommendation." NJAC: 8:39-29.4 (a) (h) (d)	F 761		

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
	062009	A. BUILDING: _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny 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 interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for residents on six (6) of 14 day shifts reviewed from 1/15/23 through 1/21/23 and 1/22/23 through 1/28/23, as mandated by the State of New Jersey. This deficient practice was identified, and the findings were as follows: Reference: New Jersey Department of Health (DOH) memo, dated 1/28/2021, "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,	S 560	1) The Staffing Coordinator called in an additional staffing agency for support. The Staffing Coordinator worked with the staffing agency and blocked a schedule for the open position to cover for the vacancies. 2) All the resdents may be affected by this practice. 3) The Staffing Coordinator will be in-serviced on staffing requirement on all 3 shifts. The Administrator and DON partner with vocational schools to utilize the students for hiring.	3/17/23

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

Electronically Signed | 03/12/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062009	A. BUILDING: _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 1/15/23 through 1/21/23 and 1/22/23 through 1/28/23, revealed the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: The facility was deficient in CNA staffing for residents on six (6) of 14 day shifts as follows: - 1/15/23 had 10 CNAs for 86 residents on the day shift, required 11 CNAs. - 1/16/23 had 9 CNAs for 86 residents on the day shift, required 11 CNAs. - 1/17/23 had 9 CNAs for 86 residents on the day shift, required 11 CNAs. - 1/23/23 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. - 1/26/23 had 10 CNAs for 85 residents on the	S 560	The recruitment department will offer a sign on bonus for the new hires. The Administrator will work with the recruitment department to simplify the hiring process and expedite hiring of candidates onsite. 4) The Staffing Coordinator will audit the staffing for 6 shifts weekly for 4 weeks then monthly for 3 months then quarterly. The The DON will report the audit 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
	062009	A. BUILDING: _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

(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 11 CNAs. - 1/28/23 had 10 CNAs for 85 residents on the day shift, required 11 CNAs. On 2/15/23 at 11:20 AM, the surveyor interviewed the staffing coordinator who stated she began the position on 2/8/23. She was unaware of the new minimum staffing requirements for nursing homes and stated, "it keeps changing." She stated, "we are short staffed and doing the best I can. We have mostly agency staff in here." There was no additional information provided.	S 560		

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
315101 Y1	A. Building B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

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 F0637	Correction	ID Prefix F0658	Correction	ID Prefix F0692	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	02/20/2023	LSC	02/27/2023	LSC	03/17/2023
ID Prefix F0710	Correction	ID Prefix F0761	Correction	ID Prefix	Correction
Reg. # 483.30(a)(1)(2)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed
LSC	03/17/2023	LSC	02/27/2023	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
2/17/2023	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062009 Y1	A. Building B. Wing Y2	4/4/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/17/2023	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	
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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/17/2023	☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 2/16/2023 and 2/17/2023 and JFK at Cedar Brook 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 Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. JFK at Cedar Brook is a One-story, Type II Un-Protected building that was built in January 1968. The facility is divided into 5 smoke zones. The facility has one emergency generator.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 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 review of facility provided documentation on 2/16/23 and 2/17/23, in the presence of facility management, it was determined that the facility failed to provide two (2) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the	K 293	1. Exit and directional signs are to be displayed with continuous illumination: a) In basement level corridor above double smoke doors by unisex bathroom b) illuminated sign with two directional arrows in the corridor near ejector room will be installed. Work was completed 3/10/2023	3/10/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/2023

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
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 293	Continued From page 1 following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code: 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign."	K 293	2. All residents may be affected by this practice 3. Maintenance purchased approved exit signs for facility. The maintenance department purchased exit signs for the facility to replace signs as needed. 4. The Maintenace Department will audit monthly for proper functioning. EXIT strategies will be reviewed by FIRE COMPANY during monthly drills with staff. Findings will be reported at QAPI quarterly meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 293	Continued From page 2 On 2/16/2023, during the survey entrance at approximately 9:33 AM a request was made to the Director of Maintenance (DOM) 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 building is a single story building with two wings (*Ex Order 26. 4B1* wings) along with a basement. On 2/16/2023 (day one of survey) starting at approximately 10:04 AM and continued on 02/17/2023 in the presence of the DOM a tour of the building was conducted. Along the tour the surveyor observed two (2) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, On 2/16/2023 at approximately 12:10 PM, one (1) illuminated exit sign on the basement level corridor above double smoke doors next to the Unisex bathroom (near the *Ex Order 26. 4B1* [redacted] office). On 02/16/2023 at approximately 12:12 PM, one (1) illuminated exit sign with two directional arrows to show that you could go either direction in the corridor near the *Ex Order 26. 4B1* room. The DOM confirmed the findings at the times of observations. The Administrator was informed of the above observations and concerns at the survey exit on 2/17/2023 at approximately 10:50 AM.	K 293		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 293	Continued From page 3 Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 311 SS=E	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility documentation on 2/16/2023, in the presence of facility Management, it was determined that the facility failed to ensure that 3 of 3 exit access stairwell doors tested were capable of maintaining the 1-1/2 hour fire rated construction. This was evidenced by the following, On 2/16/2023, during the survey entrance at approximately 9:33 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the	K 311	1. The facility has contracted with an approved vendor to provide an e-plex lock system for stairwell doors. Vendor to install: Three 3/8 x 6/8 fire doors, with 6/8 R>E> fire door hinge, e-plex lock, Von duprun 99 fire rated duro bars, and Von duprin 99 passage trims Work to be completed by vendor. Facility is requesting a time-limited waiver to replace smoke barrier doors that is estimated to be completed on 6/1/23 2. All residents may be affected by this practice.	3/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 311	Continued From page 4 facility. A review of the facility provided lay-out identified the building is a single story building with two wings (*Ex Order 26. 4B1* wings) along with a basement. There was one interior stairwell with two exit access doors on the first floor (one door leading into the dining room and one door in the corridor) and one exit access door in the basement corridor. On 2/16/2023 (day one of survey) starting at approximately 10:04 AM and continued on 2/17/2023, in the presence of the DOM, a tour of the building was conducted. During the tour at approximately 10:52 AM, during a closure test of the interior stairwell doors on the first floor, the surveyor observed that the interior stairwell's three (3) exit access doors had no means to positive latch the doors into their frames. The stairwell doors would need to positive latch into its frame to maintain the fire rated construction to prevent fire, smoke and poisonous gases to enter the exit stairwell in the event of a fire. The DOM confirmed the findings at the time. The Administrator was informed of the above observations and findings at the survey exit on 02/17/2023 at approximately 10:50 AM.	K 311	3. Director of Maintenance will in-service maintenance department and department heads for proper operation and closure of doors. Safety checks will be included in daily maintenace rounding for proper operation. Weekly rounding by department heads will include safety latch checks. 4. Audits will be reviewed at quarterly QAPI meetings for one year Daily maintenace logs will be continued Rounding will be reported at department head meeting weekly Time Limited Waiver Request Submitted to DOH Waiver with estimates/resident safety submitted to DOH	
K 324 SS=D	Fire Safety Hazard. NJAC 8:39- 31.2(e) Cooking Facilities CFR(s): NFPA 101	K 324		3/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 5 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. 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 2/16/2023, 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. The deficient practice was evidenced by the following:	K 324	1. The Director of Maintennace immediately scheduled the residential range hood inspections for semi-annually by a certfied inspection company and is non-negotiable. 2. All residents may be affected by this practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 On 2/16/23, during the survey entrance at approximately 9:33 AM, a request was made to the Director of Maintenance (DOM) to provide all mandatory inspections from 6/01/21 to 2/15/2023 for review. Review of the facility's range-hood fire suppression system inspections for the previous 20 and half months identified the system had three (3) semi-annual inspections on the following dates: - December 7, 2022, June 16, 2022, and December 6, 2021. A request was made to the DOM if the facility could provide any additional kitchen hood semi-annual inspections. The DOM provided an inspection dated for 3/22/2021. The facility did not semi-annually inspect the kitchen suppression system for the nine (9) months in 2021 between March 22, 2021 and December 6, 2021. The DOM confirmed the findings at the times of review. The Administrator was informed of the above findings at the survey exit on 2/17/2023 at approximately 10:50 AM. NFPA 101, NFPA 96 NJAC 8:39-31.2(e)	K 324	3. Director of Maintenace will maintain the calendar for the required inspections. The Director of Maintenance will set up the six month inspection dates annually. The Director of Maintenance scheduled the next inspection for April 14, 2023. DOM will schedule inspections every six months thereafter. 4. DOM will audit inspections of range hood quarterly. The Director of Maintenance will submit the audit report to Quality Assurance Committee(QAPI)	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101	K 351		3/23/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 7 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 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 2/16/2023, 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 the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition, and as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The deficient practice was evidenced by the following, On 2/16/2023, during the survey entrance at approximately 9:33 AM, a request was made to the Director of Maintenance (DOM) to provide a	K 351	1. Ex Order 26. 4B1 utility room electrical closet has no sprinkler coverage. Approved vendor installed sprinkler head in closet on 3/23/23. Associated Fire tested sprinkler for proper operation. 2. All residents may be affected by this practice. 3. Sprinklers are inspected every 3 months for proper operation by approved vendor. A comprehensive 5 year inspection is completed internally by approved vendor. Fire Drills are held monthly and reports from fire company are reviewed by Director of Maintenace.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 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 building is a single story building with two wings (*Ex Order 26. 4B1* wings) along with a basement. On 2/16/2023 (day one of survey) starting at approximately 10:04 AM and continued on 2/17/2023, in the presence of the DOM a tour of the building was conducted. During the tour at approximately 10:36 AM, an inspection inside the *Ex Order 26. 4B1* Soiled Utility room was performed. Inside the room the surveyor observed a 12" deep by 6'- 8" long electrical closet that had no evidence of fire sprinkler coverage inside. At this time, the surveyor asked the DOM, do you see a sprinkler in the closet. The DOM looked inside and stated "no." The DOM confirmed the finding at the time. The Administrator was informed of the above observations and findings at the survey exit on 2/17/2023 at approximately 10:50 AM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	4. Director of Maintenace oversees all the inspections and reports from approved fire company. DOM will provide quarterly reports of monthly fire drills and all inspections by fire company vendor and report to QAPI at quarterly meetings for one year. Reports will be reviewed by QAPI committee.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed,	K 355		3/24/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 9 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 observations on 2/16/23, in the presence of facility management, it was determined that the facility failed to failed to install portable fire extinguishers with-in the required height for 5 of 19 fire extinguishers, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 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 and N.J.A.C. 5:70. This deficient practice was evidenced by the following: Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. During the building tour on 2/16/23, in the presence of the facility Director of Maintenance (DOM), the surveyor observed and inspected Nineteen (19) portable fire extinguishers in various locations with the following findings: 1) At approximately 10:11 AM, one (1) ABC type portable fire extinguisher in the corridor between	K 355	1. The Maintenance Department has reinstalled the portable fire extinguishers in the hallways and basement area to the proper height for five (5) of our extinguishers. The extinguishers located in hallways and the basement area near the corridor were all permanently adjusted to proper regulation height. Work was completed 3/24/23 by facility maintenace department. 2. All the residents may be affected by this practice. 3. All hallways and the basement area were lowered to the regulation height. Maintenance and Administator measured for accuracy. 4. A review by fire company for proper placement and operation of exintguishers was conducted. Monthly fire drills are conducted by vendor and proper fire extinguisher placement and operation is reviewed by fire company. Maintenance provides monthly checks for fire extinguisher proper operation. Audits for fire extinguisher operation and placement are conducted by Director of Maintenance and are conducted monthly Director of Maintenace will review monthly results from fire company vendor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 10 Resident rooms [redacted] and [redacted]. This fire extinguisher appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at was mounted 5'-4-1/2" to the center of the pressure indicating needle. 2) At approximately 10:20 AM, one (1) ABC type portable fire extinguishers in the corridor between Resident rooms [redacted] and [redacted]. The surveyor measured and recorded was mounted 5'- 5" to the center of the pressure indicating needle. 3) At approximately 11:02 AM, one (1) ABC type portable fire extinguisher in the corridor between Resident rooms [redacted] and [redacted]. The surveyor measured and recorded was mounted 5'- 4" to the center of the pressure indicating needle. 4) At approximately 11:12 AM, one (1) ABC type portable fire extinguisher in the corridor between Resident rooms [redacted] and [redacted]. The surveyor measured and recorded was mounted 5'- 5" to the center of the pressure indicating needle. 5) At approximately 12:10 PM, one (1) ABC type portable fire extinguisher in the basement corridor near the Beauty Salon. The surveyor measured and recorded was mounted 5'- 7" to the center of the pressure indicating needle. The DOM confirmed the findings at the times of observations. The Administrator was informed of the above observations and findings at the survey exit on 2/17/2023 at approximately 10:50 AM. NFPA 10	K 355	and in house monthly fire extinguisher checks and report results quarterly to QAPI committee for one year	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 11 NJAC 8:39 -31.1 (c), 31.2 (e).	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 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)	K 918		3/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 12 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 2/16/23, in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 (one) of 1 (one) emergency generator was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 2/16/23, during the survey entrance at approximately 9:33 AM, a request was made to the Director of Maintenance (DOM) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments and if the facility had an Emergency Generator. The DOM told the surveyor, "yes, we have a Diesel Generator." On 2/16/2023 (day one of survey) at approximately 11:36 AM, an inspection outside of the building where the Emergency Generator was located was performed. The surveyor observed that the emergency shut off was located on the generator's control panel inside the metal housing. At that same time, the surveyor requested if the facility had a remote emergency stop button that was not inside the housing of the generator. The DOM told the surveyor, there is a remote emergency stop button inside the building by the generator transfer switch.	K 918	1. The emergency generator requires a remote manual stop station located outside of the generator's control panel. A sport modern emergency switch has been order from an approved vendor. The emergency stop switch will be installed by the Director of Maintenance who is a licensed electrician. The switch has been ordered and we have applied for a Time Limited Waiver Request. Anticipated completion for corrective action is 6/01/2023. 2. All residents may be affected by this practice. 3. Generator checks are performed weekly and logged for time and date. The weekly log book will include the remote manual stop switch to assure proper operation. The Director of Maintenace will in-service his department for proper operation and testing of remote emergenecy shut off switch. 4. Audits will be reviewed monthly by Maintenace Director for proper testing of generator, switch and shut off. Audits will be reported at quarterly QAPI meetings for one year Time Limited Waiver Request was submitted to DOH	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**02/17/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	**1340 PARK AVE** **PLAINFIELD, NJ 07060**

(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 On 2/17/2023 (day two of survey), an inspection of the emergency generators transfer switch was conducted. The surveyor observed no evidence of a remote emergency stop button. The DOM confirmed the findings at the times of observations. The Administrator was informed of the above observations and findings at the survey exit on 02/17/2023 at approximately 10:50 AM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	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
315101 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/9/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PLAINFIELD LLC	1340 PARK AVE PLAINFIELD, NJ 07060

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 K0293	03/10/2023	LSC K0311	03/30/2023	LSC K0324	03/10/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	03/23/2023	LSC K0355	03/24/2023	LSC K0918	03/30/2023
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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/17/2023	☐ YES ☐ NO