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 _____	C 03/20/2025

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

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F 000	INITIAL COMMENTS Complaint #: NJ00163677, NJ00164854, NJ00182708 Survey Date: 3/13/2025 TO 3/20/2025 Census: 95 Sample: 20 + 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 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following	F 880		4/7/25

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

Electronically Signed | 04/04/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 2 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review and other pertinent facility documentation it was determined that the facility failed to use appropriate infection control practices to prevent the spread or reduce the risk of [NJ Exec Order 26.4b] for a.) provision of [NJ Ex Order 26.] care for 1 of 2 residents (Resident # 90) reviewed for [NJ Ex Order 26.4(b)(1)] b.) proper use of personal protective equipment (PPE) for a resident on [NJ Ex Order 26.4(b)(1)]) for 1 of 1 residents reviewed for EBP, (Resident #8) and c.) properly storing [NJ Ex Order 26.4(b)(1)] in a protective bag when not in use by the resident for 1 of 2 residents (Resident #70) reviewed for [NJ Ex Order 26.4(b)(1)] care. This deficient practice was identified by the following: 1.) On 3/13/25 at 10:57 AM, the surveyor observed Resident #90 in the room, sitting up in a chair. The resident stated they had a [NJ Ex Order 26.4(b] . The surveyor observed the resident wearing [NJ Ex Order 26.4(b)(1)] to the [NJ Ex Order 26.4(b] . The resident denied [NJ Ex Ord] or [NJ Ex Order 26.4(b)(1)] On 3/14/25 at 9:11 AM, the resident was observed lying in bed with head of the bed up. The surveyor interviewed the resident at that time and the Resident stated that that they had no concerns. The surveyor observed that the resident was wearing [NJ Ex Order 26.4(b)(1)] to the [NJ Ex Order 26.4(b)(1)] .	F 880	Deficiency: F880 – Wound care The facility will conduct an annual review of its IPCP and update their program, as necessary. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Staff member was educated on proper [NJ Ex Order 26.] care technique, handwashing, and PPE protocol. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/designee will educate all nurses on the process of following PPE protocol, handwashing, and wound care techniques. In-service will be conducted by DON/designee will educate nurses on infection control practices for wound treatments. 4. HOW THE FACILITY WILL	

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F 880	Continued From page 3 A review of the Admission Record (AR) (admission summary) indicated that Resident #90 was admitted to the facility with the diagnoses which included but was not limited to; NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) A review of the quarterly Minimum Data Set (MDS) an assessment tool that facilitates a resident's care, dated NJ Ex Order 26.4(b)(1), indicated the resident had a Brief Interview for Mental Status (BIMS) of NJ Ex out of 15, indicating the resident had NJ Ex Order 26.4(b)(1) and had an NJ Ex Order 26.4(b)(1). The surveyor reviewed the Treatment Administration Record (TAR) which contained a physician's orders (PO) dated NJ Ex Order 26 to NJ Ex Order 26.4(b)(on the day shift (7:00 AM-3:00 PM) for NJ Ex Order 26. care of the NJ Ex Order 26.4(b)(. Treatment consisted of the following steps: 1. Cleanse with NJ Ex Order 26.4((a NJ Ex Order 26.4(b)(1) solution. 2. Apply NJ Ex Order 26 (NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) to the NJ Ex Order of the NJ Ex Order 26.4(3. Secure with NJ Ex Order 26.4(b)(1) 4. Change the NJ Ex Order 26.4(b)(daily. On 3/14/25 at 9:27 AM, the surveyor observed	F 880	MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: DON/Designee will conduct 2 treatment competency evaluation weekly x 4 weeks then 2 treatment competency evaluations bimonthly x 2 months. DON/designee will conduct a weekly audit of handwashing and PPE protocol. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly. Deficiency: F880 – Enhanced Barrier Precautions The facility will conduct an annual review of its IPCP and update their program, as necessary. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Staff member was educated on proper use of personal protective equipment (PPE) when caring for residents on NJ Ex Order 26.4(b)(1)) 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice.	

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F 880	Continued From page 4 Licensed Practical Nurse (LPN #1) perform NJ Ex Order 26.4 care for Resident #90's NJ Ex Order on the NJ Ex O - LPN #1 was observed applying an NJ Ex Order 26.4(b) and with an ungloved, unwashed hand remove NJ Ex Order 26.4(b)(1) from a large packet of NJ Ex Order 26.4(b)(1) and then remove other items from the clean treatment cart. The LPN then put NJ Ex Order 26.4(b)(1) on top of the other items that she removed from the treatment cart such as a NJ Ex Order 26.4(b)(1), a box of NJ Ex Order 26.4(b)(1) and a bottle of NJ Ex Order 26.4(b)(1). The LPN did not disinfect the surface or set up a clean field on top of the resident's bedside nightstand and placed the NJ Ex O, NJ Ex Order 26.4(b)(1), box of NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) on the nightstand. -LPN #1 then washed her hands and applied gloves. LPN #1 with the gloves on, touched the resident's blanket and removed the resident's NJ Ex Order 26.4 and NJ Ex Order 26. The LPN did not wash her hands or change her gloves and proceeded to touch the bottle of NJ Ex Order 26.4(b)(1) and NJ Ex Order 26 . She proceeded to NJ Ex Order 26.4(b) on the NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1 the resident's NJ Ex Order 26.4(b)(1). -LPN #1 then removed her gloves, washed her hands and applied new gloves and went to the treatment cart to retrieve NJ Ex Order 26.4(b)(1). The LPN laid the NJ Ex Order 26.4(b)(1) directly on the surface of the undisinfected nightstand. She then opened the NJ Ex Order 26.4(b)(1) and placed the lid of the NJ Ex Order 26 on the resident's bed linen and placed the uncapped NJ Ex Order 26.4(b)(1) on the resident's nightstand with the tip of the opened NJ Ex Order 26 lying	F 880	3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/designee will educate all nurses on the proper use of personal protective equipment (PPE) when caring for residents on enhanced barrier precautions (EBP) 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: DON/Designee will conduct 2 enhanced barrier precautions evaluation weekly x 4 weeks then 2 enhanced barrier precautions evaluations bimonthly x 2 months. DON/designee will conduct a weekly audit of PPE protocol. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly. Deficiency: F880 -Respiratory Equipment Storage The facility will conduct an annual review of its IPCP and update their program, as necessary. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE	

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F 880	Continued From page 5 directly in contact with the surface of the undisinfected nightstand. She then applied the santyl to the NJ Ex Order 26.4(b)(1) to apply to the resident's NJ Ex Order 26.4(b)(1). - LPN #1 then removed her gloves and walked to the treatment cart to retrieve a new pair of gloves. She retrieved the gloves and put them in her back pocket. She then washed her hands, took the gloves out of her back pocket, applied the gloves and then applied the NJ Ex Order 26.4(b)(to the NJ Ex Order 26.4(b. She then proceeded to sign the NJ Ex Order 26.4(b)(with the date and initials with a black marker, while the NJ Ex Order 26.4(b)(was on the resident. On 3/14/25 at 9:49 AM, the surveyor reviewed the above mentioned NJ Ex Order 26 care observations with LPN #1. LPN #1 admitted that there were multiple breaks in infection control while she was performing the NJ Ex Order 26.4 care to the resident's NJ Ex [redacted] and explained that the breaks in infection control could potentially expose the resident to infection. On 3/14/25 at 10:03 AM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM #1). The surveyor explained the NJ Ex Order 26.4 care observations for Resident #90s NJ Ex Order 26.4(b) . RN/UM #1 stated that LPN #1 needed more training related to infection control when performing treatments and should also not date NJ Ex Order 26.4(b)(1) while on a resident because it was a dignity issue. She confirmed that LPN #1 should have disinfected and set up a clean field on the table that she was using to place the treatment supplies. RN/UM #1stated LPN #1 should not have put an ungloved hand in the package of NJ Ex Order 26.4(b)(1) because it could contaminate all the NJ Ex Order 26.4(b)(1) in the package. RN/UM #1 also confirmed LPN#1	F 880	RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident #70 was assessed by primary nurse. NJ Ex Order 26.4(b)(1) was removed. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON/Designee educated all nurses regarding proper storage of respiratory equipment in when not in use. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: DON/Designee will audit physician orders for 5 residents with oxygen orders for proper storage weekly x 4 weeks and monthly x 2. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.	

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should not have put gloves in her back pocket before applying them, put the [redacted] to the [redacted] in the resident's bed on the bed linen or put the NJ Ex Order 26.4(b)(1) with the opening of the [redacted] to lie directly on an undisinfected surface. RN/UM #1 added LPN #1 should not have laid the NJ Ex Order 26.4(b)(1) directly on the unclean resident nightstand. She stated that these were all breaks in infection control while performing [redacted] care.

On 3/14/24 at 10:30 AM, the surveyor interviewed the facility U.S. FOIA (b) (6)) as well as the U.S. FOIA (b) (6)), who confirmed that LPN #1 should have performed hand hygiene and applied gloves before putting her hand in the packet of clean NJ Ex Order 26.4(b)(1) and should have prepped the nightstand by cleaning with disinfectant and putting down a clean field. The both also confirmed that the [redacted] could become contaminated because LPN #1 put the NJ Ex Order 26.4(b)(1) in the resident's bed linen and laid the NJ Ex Order 26.4(b)(1) directly in contact with the undisinfected nightstand surface. They both confirmed LPN #1 had multiple breaks in infection control and that the resident's treatment would be re-done immediately.

A review of the facility policy, dated 11/2018 and titled, "Wound Care" indicated that the procedure for wound care was to set up a clean field utilizing a disposable cloth and to place all items to be used during the procedure on the clean field. The policy specified that all clean items were to be on a clean field. The policy indicated that the staff were to wipe nozzles, foil packets, bottle tops etc. with alcohol before opening as necessary. The policy also indicated that after dressing were removed the staff member was to wash hands

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thoroughly and put on gloves and to wipe reusable supplies with alcohol (outside of containers that were touched with unclean hands) and return to the treatment cart.

2.) On 3/13/25 at 12:02 PM, the surveyor observed signage posted on Resident #8's door that the resident was NJ Ex Order 26.4(b)(1) [redacted]) (NJ Ex Order 26.4(b)(1) [redacted]). The posting indicated that staff were to wear gloves and NJ Ex Order 26.4(b)(1) when performing direct resident care. There was also an NJ Ex Order 26.4(b)(1) hanging on the door which contained, gloves, gowns and mask. The resident was observed out of bed. The surveyor was unable to interview the resident due to the resident NJ Ex Order 26.4(b)(1) [redacted] . The resident was observed to be clean and well dressed.

On 3/14/25 at 8:56 AM, the surveyor observed Resident #8 in NJ Ex Order 26.4(b)(1) . The resident was sleeping, and NJ Ex Order 26.4(b)(1) was observed.

On 3/14/25 at 8:59 AM, the surveyor observed the U.S. FOIA (b) (6) [redacted]) assist the resident out of bed. The signage on the resident's door indicated that a gown and gloves were to be donned (applied) for NJ Ex Order The surveyor did not observe the U.S. FOIA (wearing the necessary personal protective equipment (PPE) such as a gown and gloves prior to direct resident care such as transferring the resident from the bed to the chair.

On 3/14/25 at 9:01 AM, the surveyor interviewed the U.S. FOIA (b) who stated that the resident required

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total care and had a NJ Ex Order 26.4(b)(1). The U.S. FOIA (stated that the resident was NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) . The U.S. FOIA (admitted that while performing direct resident care, she was supposed to don a gown and gloves. She stated that it would have been important to wear the proper PPE to protect the resident from infection. She stated she did not apply the PPE because she forgot. She explained that she was educated multiple times on the importance of applying PPE and should follow the directions according to the signage on the resident's door.

A review of the AR indicated that Resident #8 was admitted to the facility with diagnoses which included but was not limited to NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) NJ Ex).

A review of the comprehensive MDS, dated NJ Ex Order 26 , indicated that the resident had a BIMS of NJ Ex C which indicated the resident had NJ Ex Order 26.4 ; required NJ Ex Order 26.4(b)(1) with activities of daily living and NJ Ex Order 26.4(b)(1) were met by way of NJ Ex Order 26.4(b)(1)

The surveyor reviewed a physician's order dated NJ Ex Order 26 , that Resident #8 was on NJ Ex Order 26.4(b)(1) related to (r/t) NJ Ex Order 26.4(b)(1)).

The surveyor reviewed the resident's Individual Comprehensive Care Plan (ICCP) dated NJ Ex Order 26.4(b) which reflected the following:

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F 880	Continued From page 9 Focus: Resident #8 required NJ Ex Order 26.4(b)(1) related to NJ Ex Order 26.4(b)(1) : NJ Ex Order 26.4(b)(1) Interventions: -Clear signage must be posted on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., NJ Ex Order 2 and gloves). For NJ Ex Order 26.4(b)(1) , signage should also clearly indicate the NJ Ex Order 26.4(b)(1) resident care activities that require the use of gown and gloves. PPE, including gowns and gloves must be available immediately outside of the resident room. U.S. FOIA (b Nurse] - NJ Ex Orde will be in place for the duration of Resident #8's stay in the facility or until resolution or discontinuation of the NJ Ex Order 26.4(b)(1) that placed them at higher risk. On 3/14/25 at 11:40 AM, the surveyor interviewed the U.S. F who confirmed the U.S. FOIA (b) who transferred the resident should have worn the appropriate PPE and was required to don a gown and gloves prior to performing direct resident care. Transferring a resident is a form of direct resident care. The U.S. confirmed that this was a break in infection control and facility policy. The facility policy dated 11/21/2023 and titled, "Enhanced Barrier Precautions" indicated that EBP wound be implemented for any residents with wounds and indwelling medical devices. According to the policy staff were to use PPE-gown and gloves during high contact resident care. 3.) On 3/13/25 at 10:38 AM, during initial tour of the facility, the surveyor observed Resident #70 resting in their bed with their eyes closed. Behind	F 880		

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F 880	Continued From page 10	F 880		

the resident's bed, was a NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) attached that had a NJ Ex Order 26.4(b)(1) attached to it and was coiled around and hanging off the NJ Ex Order 26.4(b)(1). The NJ Ex Order 26.4(b)(1) was not stored in the plastic bag which was also hanging off the NJ Ex Order 26.4(b)(1).

On 3/14/25 at 9:59 AM, the surveyor observed Resident #70's NJ Ex Order 26.4(b)(1) was stored in the same NJ Exec Order 26.4 and NJ Exec Order 26.4b1 as was observed the previous day. The resident was not in their room at this time.

On 3/17/25 at 10:03 AM, the surveyor reviewed Resident #70's medical record and the following was indicated:

A review of the resident's AR indicated that the resident was admitted to the facility with diagnosis which included but was not limited to: NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)

A review of the resident's quarterly MDS dated NJ Ex Order 26.4(, indicated the resident had a BIMS score of NJ out of 15, which indicated NJ Ex Order 26.4(b)(1) and was receiving NJ Ex Order 26.4(b)(1).

A review of the resident's physician's Order Summary Report indicated an order with start date of NJ Ex Order 26.4(, to apply NJ Ex Order 26.4(per NJ Ex Order every shift, and a second order with a start date NJ Ex Order 26.4(, to NJ Ex Order 26.4(b)(1) weekly and label and date with residents name of each component.

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 _____	C 03/20/2025

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 880	Continued From page 11 A review of the resident's ICCP indicated a focus care area initiated on [NJ Ex Order 26.4(b)] for risk for NJ Ex Order 26.4(b)(1). On 3/18/25 at 12:32 PM, the surveyor observed Resident #70 in their room NJ Ex Order 26.4(b)(1) and having lunch. The resident was not receiving [NJ Ex Order 26.4(b)] and the NJ Ex Order 26.4(b)(1) was attached to the NJ Ex Order 26.4(b)(1) on the wall behind the resident's bed and draped over the NJ Ex Order 26.4(b)(1) not stored in a protective bag. On 3/18/25 at 12:32 PM, the surveyor interviewed LPN #2, who stated NJ Ex Order 26.4(b)(1) should always be stored in a protective bag when not in use to prevent contamination and to follow infection control practices. On 3/18/25 at 1:26 PM, the surveyor interviewed LPN/UM #2, who stated that NJ Ex Order 26.4(b)(1) should be stored in a protective bag when not in use to maintain infection control. On 3/18/25 at 1:36 PM, the surveyor and LPN/UM #2, observed the conditions in which Resident #70's NJ Ex Order 26.4(b)(1) was being stored in the resident's room, to which LPN/UM #2 acknowledged that it should not have been stored draped over the NJ Ex Order 26.4(b)(1) and outside of a protective bag. LPN/UM #2 further acknowledged that the [NJ Ex Order 26] should have been in a protective plastic bag while not in use. On 3/28/25 at 1:53 PM, the surveyor interviewed the U.S. FOIA (b) (6)), who confirmed that when not in use, NJ Ex Order 26.4(b)(1) and [NJ Ex Order 26.4(b)] should have been stored in a protective plastic bag to maintain infection control.	F 880		

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 _____	C 03/20/2025

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 880	Continued From page 12 A review of the facility's "Oxygen Administration" policy with an updated date of 1/2024, did not include procedure to properly store respiratory tubing when not in use. On 3/29/25 at 9:52 AM, the [U.S. FOIA (b)] in the presence of the survey team, provided the surveyor with a revised copy of the "Oxygen Administration" policy and stated that the facility revised the policy after surveyor inquiry to include: "equipment maintenance and storage: ... e. keep delivery devices covered in plastic bag when not in use." NJAC 8:39-19.1; 8:39-27.1(e)	F 880		

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 _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: NJ Complaints #: NJ00164854 Based on interview and review of pertinent facility documents, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 16 of 21 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	S 560	Deficiency: S560 How the corrective action will be accomplished for those residents found to have been affected by the practice: Inadequate number of CNA□s How the facility will identify other residents having the potential to be affected by the deficient practice: The facility recognizes that all residents have the potential to be affected by this practice. What measures will be put into place or what systemic changes will be made to ensure that deficient practice will not	4/7/25

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

Electronically Signed | 04/04/25

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 _____	C 03/20/2025

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S 560	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 06/04/2024 to 06/10/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -06/05/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. -06/06/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -06/07/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -06/08/24 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. 2. For the 2 weeks of staffing prior to survey from 02/23/2025 to 03/08/2025, the facility was deficient in CNA staffing for residents on 12 of 14 day shifts as follows:	S 560	recur: The Administrator will review Staffing Coordinator in reference to the state guideline S560.¿The Director of Human Resources will continue to post the vacancies on all 3 shifts.¿The Director of Human Resources will schedule the Open House.¿The Administrator will boost the rate when there is emergency staffing coverage. Human Resources recruits from various local colleges and other schools with CNA programs by direct contact and attendance at Job Fairs. Employee Referral Bonus Program was implemented. Regular meetings are held including the Administrator, Director of Nursing and Human Resources to review direct care staffing and develop strategies for recruitment and retention of direct care staff. How the facility will monitor its corrective actions to ensure that the deficient practice will not recure, I.E., What quality assurance program will be put into. The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 3 months.¿The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee quarterly.	

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 _____	C 03/20/2025

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S 560	Continued From page 2 -02/23/25 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/24/25 had 10 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/25/25 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/26/25 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -02/27/25 had 9 CNAs for 99 residents on the day shift, required at least 12 CNAs. -02/28/25 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -03/01/25 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -03/02/25 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -03/03/25 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -03/04/25 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs. -03/07/25 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -03/08/25 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. On 03/18/2025 at 11:57 AM, the surveyor interviewed the facility staffing coordinator (SC). The surveyor asked the SC if she was familiar with the state minimum staffing mandate requirements for the state of New Jersey. The SC told the surveyor the following: "for 7-3 shift it is 1 CNA to 8 residents, 3-11 shift is 1 to 10 and 11-7 shift is 1 to 14." The surveyor then asked the SC if the facility consistently met the requirement to which the SC stated, "as best as we can, but do not always meet it all the time." On 3/20/25 at 2:30 PM, the surveyor interviewed the Licensed Nursing Home Administrator who	S 560		

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 _____	C 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 stated the required staffing requirements is 1 to 8 during the morning shift, 1to 10 for the afternoon, and 1 to 14 in the evening. He further stated that he feels the facility meets the staffing requirements and "very few times we are not." He stated any staffing shortage would be a cause of call outs. A review of the facility's provided policy titled "Staffing" with updated date of 1/2023 indicated the following: "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment."	S 560		
S1680	8:39-25.2(b)(1)&(2) Mandatory Nurse Staffing (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00	S1680		4/7/25

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 _____	C 03/20/2025

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S1680	Continued From page 4 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day	S1680		

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 _____	C 03/20/2025

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S1680	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 02/23/2025 to 03/08/2025, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 03/02/25 Required Staffing Hours: 269.75 -03/07/25 had 264 actual staffing hours, for a difference of -5.75 hours. During an interview on 3/18/25 at 11:57 AM, the Staffing Coordinator (SC) stated that the facility attempted to fulfill staffing mandates "as best as we can, but do not always meet it all the time." A review of the facility's provided policy titled "Staffing" with updated date of 1/2023 indicated the following: "Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment."	S1680	Deficiency: S1680 How the corrective action will be accomplished for those residents found to have been affected by the practice: Inadequate required staffing hours. How the facility will identify other residents having the potential to be affected by the deficient practice: The facility recognizes that all residents have the potential to be affected by this practice. What measures will be put into place or what systemic changes will be made to ensure that deficient practice will not recur: The Administrator will review Staffing Coordinator in reference to the state guideline S1680.¿The Director of Human Resources will continue to post the vacancies on all 3 shifts.¿The Director of Human Resources will schedule the Open House.¿The Administrator will boost the rate when there is emergency staffing coverage. The Administrator, DON, and/or designee will offer a bonus on top of the overtime and/or regular hourly pay. Employee Referral Bonus Program was implemented. Regular meetings are held including the Administrator, Director of Nursing and Human Resources to review direct care staffing and develop strategies for recruitment and retention of direct care staff. Facility will reach out to staffing agencies for temporary and permanent	

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 _____	C 03/20/2025

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S1680	Continued From page 6	S1680	staffing assistance. How the facility will monitor its corrective actions to ensure that the deficient practice will not recure, I.E., What quality assurance program will be put into. The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 3 months.¿The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee quarterly.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315101 Y1	A. Building B. Wing Y2	4/22/2025 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 F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	04/07/2025	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?
3/20/2025	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062009 Y1	A. Building B. Wing Y2	4/22/2025 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 S1680	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-25.2(b)(1)&(2)	Completed	Reg. #	Completed
LSC	04/07/2025	LSC	04/07/2025	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	
3/20/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315101	A. BUILDING **01** B. WING _____	**03/20/2025**

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

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health and Senior Services on 03/20/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 03/20/25 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Plainfield is a one-story building with a partial basement constructed in 1968. It is composed of Type III (200) construction and is divided into seven smoke compartments. The facility has a complete automatic sprinkler system (wet with antifreeze). The diesel generator powers 100% of the building. The number of occupied beds was 95 out of 106. The facility has a piped-in oxygen medical gas system installed in all residents' rooms. The facility does not have residents on life support.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211		4/1/25

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

Electronically Signed | 04/07/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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 _____	**03/20/2025**

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 211	Continued From page 1 exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the means of egress was maintained to be free of all obstructions as required by NFPA 101 Life Safety Code (2012 Edition) Chapter 7. This deficient practice had the potential to affect staff and 4 residents and was evidenced by the following: An observation on 03/20/25 at 8:30 AM, 12:30 PM, and 4:30 PM of the designated exit corridor in the Basement revealed pallets with large boxes stored in the means of egress by Laundry and the Conference Room. The Basement is currently used by residents for the rehab gym. An interview with the U.S. FOIA (b) (6) [redacted] at the time of the observation revealed the facility was not aware pallets and boxes could not be stored in the exit Corridor.	K 211	K211 1. We Immediately removed all obstructions in the means of egress in the Basement, ensuring that the exit corridor is clear and accessible for residents and staff. 2. Staff and 4 Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director or designee will audit monthly X three months to ensure the exit corridor remains clear and accessible. 4. The Maintenance Director or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings x two quarters.	
K 353 SS=F	NJAC 8:39-31.2(e) Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design,	K 353		4/4/25

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 _____	**03/20/2025**

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K 353	Continued From page 2 maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition), Sections 5.2 and 5.4. This deficient practice had the potential to affect all 95 residents and was evidenced by the following: A review on 03/20/25 at 9:30 AM of the sprinkler facility's sprinkler inspection and testing record revealed that monthly inspections of the gauges for the wet sprinkler system were not conducted. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was not aware that gauges for the wet sprinkler system were required to be inspected monthly. An observation on 03/20/25 at 11:20 AM of the sprinkler heads in the Kitchen revealed quick response glass bulb sprinkler heads were installed.	K 353	K353 1. We reached out to our contracted company to send the missing head. We immediately inspected the gauges for the wet sprinklers system. 2. All residents have the potential to be affected by the deficient practice. 3. The Maintenance Director or designee will audit monthly X three months to ensure that the inspection of the 2 sprinkler gauges in the boiler room were conducted. 4. The Maintenance Director or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings x two quarters.	

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	315101	A. BUILDING **01** B. WING _____	**03/20/2025**

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K 353	Continued From page 3 An observation on 03/20/25 at 2:30 PM of the spare sprinkler cabinet, located in the Basement at the sprinkler riser, revealed that samples of quick response glass bulb-type sprinkler heads were not provided for replacements. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility was not aware that spare glass bulb-type sprinklers were missing prior to the survey. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open	K 363		4/1/25

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	315101	A. BUILDING **01** B. WING _____	**03/20/2025**

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K 363	Continued From page 4 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.6.3. This deficient practice had the potential to affect 22 residents and was evidenced by the following: An observation on 03/05/24 at 12:20 PM revealed the corridor door of room 111 failed to close in the door frame. An observation on 03/05/24 at 12:22 PM and 3:30 PM revealed the corridor door of room 113 was blocked from closing and latching in the door frame by a trash can. During an interview at the time of the observations, the U.S. FOIA (b) (6)	K 363	K363 1. We immediately inspected and repaired the following corridor doors to ensure they close and latch properly into the frame. 2. 22 Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director or designee will audit the corridor doors monthly X three months to ensure that the corridor doors room 11 and 13 properly close and latch properly into the door frame. 4. The Maintenance Director or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings x two quarters.	

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K 363	Continued From page 5 confirmed the findings and stated the facility was unaware the doors were not closing and latching prior to the survey.	K 363		
K 918 SS=F	NJAC 8:39-31.2(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	K 918		4/16/25

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K 918	Continued From page 6 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to maintain the generator in accordance with NFPA 110 Emergency Power and Standby Power Systems (2010 Edition), Section 8.3.8. This deficient practice had the potential to affect all 95 residents and was evidenced by the following: A review on 03/20/25 at 2:45 PM of the facility's Generator Inspection & Testing Records revealed that documentation of the annual fuel quality test of the diesel generator was not provided. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the finding and revealed the facility had not conducted a fuel quality test report. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	K918 1. The facility contracted a company to perform the fuel quality test. 2. All residents have the potential to be affected by the deficient practice. 3. The Maintenance Director or designee will audit the generator book monthly X three months to ensure that the documentation of the fuel quality test is available. 4. The Maintenance Director or designee will report the findings of these audits at the quarterly Quality Assurance and Performance Improvement meetings x two quarters.	

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	4/22/2025 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 K0211	04/01/2025	LSC K0353	04/04/2025	LSC K0363	04/01/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	04/16/2025	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	
3/20/2025	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO