STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315122	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD , WESTFIELD, New Jersey, 07090**

(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
F0000	INITIAL COMMENTS The NJDOH conducted a Complaint survey on 11/6/25. The survey was officially completed on 11/6/25. Complaint #: NJ00187032 Complaint Survey: 11/6/25 Census: 194 Sample Size: 3 A Complaint Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. The facility is in compliance with the Requirements of 42 CFR part 483, subpart B, for Long Term Care Facilities.	F0000		11/18/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD , WESTFIELD, New Jersey, 07090

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S0000	Initial Comments THE FACILITY WAS 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.	S0000		11/18/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 20 out of 21-day shifts reviewed. Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021: One CNA to every eight residents for the day shift.	S0560	S560- Mandatory Access to Care. Residents affected by deficient practice: The facility failed to comply with applicable Federal, State, and local laws, rules, and regulations by not ensuring staffing ratios were met. No residents were identified to be affected by this deficient practice. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by this deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: The Administrator, Director of Nursing, and Staffing Coordinator were re-educated on the minimum staffing requirements. The facility has contracted with multiple staffing agencies to supplement their staff for the missing shifts in an effort to meet the staffing ratios. Measures or systemic changes to ensure that the deficiencies will not recur:	11/23/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD , WESTFIELD, New Jersey, 07090

(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
S0560	Continued from page 1 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. As per the "Nursing Staffing Report" completed by the facility as documented below: • For the 3 weeks of AAS-11 staffing, the facility was deficient as follows: 1. For the week of Complaint staffing, the facility was deficient in CNA staffing for residents on 6 of 7 day shifts as follows: -05/25/25 had 23 CNAs for 191 residents on the day shift, required at least 24 CNAs. -05/26/25 had 22 CNAs for 190 residents on the day shift, required at least 24 CNAs. -05/27/25 had 22 CNAs for 186 residents on the day shift, required at least 23 CNAs. -05/29/25 had 21 CNAs for 186 residents on the day shift, required at least 23 CNAs. -05/30/25 had 22 CNAs for 186 residents on the day shift, required at least 23 CNAs. -05/31/25 had 22 CNAs for 186 residents on the day shift, required at least 23 CNAs. 2. For the 2 weeks of Complaint staffing from 10/19/2025 to 11/01/2025, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -10/19/25 had 21 CNAs for 192 residents on the day shift, required at least 24 CNAs. -10/20/25 had 21 CNAs for 192 residents on the day shift, required at least 24 CNAs.	S0560	Continued from page 1 The administrator/designee will participate in a weekly call for 3 months with a recruitment team to review open positions and recruitment tactics to improve hiring outcomes to meet the required staffing ratio. The Administrator/designee will review the staffing sheets daily to ensure compliance with the staffing ratios. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for three months and then quarterly. Results of audit will be shared by Administrator or designee and reviewed with the IDT team at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Any recommended actions will be implemented as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

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S0560	Continued from page 2 -10/21/25 had 21 CNAs for 192 residents on the day shift, required at least 24 CNAs. -10/22/25 had 21 CNAs for 192 residents on the day shift, required at least 24 CNAs. -10/23/25 had 21 CNAs for 192 residents on the day shift, required at least 24 CNAs. -10/24/25 had 21 CNAs for 192 residents on the day shift, required at least 24 CNAs. -10/25/25 had 22 CNAs for 192 residents on the day shift, required at least 24 CNAs. -10/26/25 had 22 CNAs for 191 residents on the day shift, required at least 24 CNAs. -10/27/25 had 21 CNAs for 189 residents on the day shift, required at least 24 CNAs. -10/28/25 had 22 CNAs for 186 residents on the day shift, required at least 23 CNAs. -10/29/25 had 21 CNAs for 186 residents on the day shift, required at least 23 CNAs. -10/30/25 had 21 CNAs for 186 residents on the day shift, required at least 23 CNAs. -10/31/25 had 21 CNAs for 186 residents on the day shift, required at least 23 CNAs. -11/01/25 had 21 CNAs for 188 residents on the day shift, required at least 23 CNAs.	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315122	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD , WESTFIELD, New Jersey, 07090**

(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
F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/5/2025 in relation to the 11/6/2025 Complaint survey. The facility was found to be in compliance with 42 CFR Part 843, Requirements for Long Term Care Facilities.	F0000		12/06/2025

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 reverse for further 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.

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **062013**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **12/05/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/5/2025 in relation to the 11/6/2025 State of New Jersey Complaint survey. The facility was found to be in compliance with the Standards in the new jersey Administrative Code, chapter 8:39, Standards for Licensure of Long Term Care Facilities.	S0000		12/06/2025

Office of Primary Care and Health Systems Management

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