

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315273	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 WOODLAND AVE , PLAINFIELD, New Jersey, 07060
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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) COMPLETION DATE
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F0000	<p>INITIAL COMMENTS</p> <p>A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH).</p> <p>Survey Dates: 07/21/25 – 07/24/25</p> <p>Survey Census: 106</p> <p>Sample Size: 28</p> <p>Supplemental Sample: 20</p> <p>The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.</p>	F0000		08/08/2025
F0759 SS = D	<p>Free of Medication Error Rts 5 Prcnt or More</p> <p>CFR(s): 483.45(f)(1)</p> <p>§483.45(f) Medication Errors.</p> <p>The facility must ensure that its-</p> <p>§483.45(f)(1) Medication error rates are not 5 percent or greater;</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, record review, and review of facility policy and manufacturer's instructions, the facility failed to ensure a medication error rate below five percent. During medication administration for one (Resident (R)133) of seven residents, two medication errors occurred out of 31 opportunities for error, or a medication error rate of 6.45%. This failure had the potential to increase or decrease the effectiveness of these medications.</p> <p>Findings include:</p> <p>Review of the facility's policy titled "Medication Administration" dated 06/01/2025 indicated, "... 10. Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug, c.</p>	F0759	<p>Deficiency: F759</p> <p>Free of Medication Error Rates of 5% or More</p> <p>HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: LPN 1 was immediately educated on following physician's orders and instructions regarding RI Exec Order of medications. R133's medications were immediately reviewed and modified.</p> <p>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.</p> <p>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 following physician's orders and instructions regarding crushing of medications.</p> <p>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 4 medication</p>	09/01/2025

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F0759 SS = D	<p>Continued from page 1 Right dosage, d. Right route, e. Right time, f. Right documentation....17. Administer medication as ordered in accordance with manufacturer specifications.... c. Crush medications as ordered. Do not crush medications with "do not crush" instructions.... Do Not Crush Mediations: Slow release, Enteric coated, Crushed meds are not to be combined and given all at once...."</p> <p>Observation during the medication administration on 07/23/25 at 9:20AM, Licensed Practical Nurse (LPN) 1 administered to R133 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 one tablet which were all NJ Exec Order 26.4b1 and placed in NJ Exec Order 26.4b1.</p> <p>Review of R133's "Face Sheet" located under the "Profile" tab "Admission Record" in the electronic medical record (EMR) revealed R133 was originally admitted to the facility on NJ Exec Order 26.4b1 with the diagnosis of NJ Exec Order 26.4b1</p> <p>Review of R133's "Physician Orders" provided by the facility revealed "NJ Exec Order 26.4b1 Give 1 capsule by mouth one time a day for NJ Exec Order 26.4b1 of the NJ Exec Order 26.4b1 do not NJ Exec Order 26.4b1 open or chew dated NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1 tablet by mouth two times a day for NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b1."</p> <p>During the interview on 07/23/25 at 10:05AM, when asked why the two medications were NJ Exec Order 26.4b1 LPN1 replied, "There is this little statement at top of screen that says, NJ Exec Order 26.4b1 and place in NJ Exec Order 26.4b1."</p> <p>During the interview on 07/23/25 at 4:25PM, the US FOIA (b)(6) stated that staff were in-serviced on whether medications can be NJ Exec Order 26.4b1</p> <p>Review of NJ Exec Order 26.4b1 manufacturer recommendation revealed that NJ Exec Order 26.4b1 should not be NJ Exec Order 26.4b1 chewed, or opened.</p> <p>Review of the NJ Exec Order 26.4b1 manufacturer recommendation revealed crushing NJ Exec Order 26.4b1 tablets is generally not recommended due to crushing this medication can change the way the medication is delivered to the blood stream and for the medication not to work as it is manufactured and designed to perform in one's body.</p> <p>NJAC 8:39-29.2(d)</p>	F0759	<p>Continued from page 1 observation passes weekly x 4, then conduct 4 medication observation passes monthly x2. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly.</p> <p>Completion Date 09-01-2025</p>	

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New Jersey State Department of Health

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S0000	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.	S0000		08/08/2025
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 review of pertinent facility documentation, 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. Findings include: 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. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift.	S0560	Mandatory Access to Care S 560 Staffing How the corrective action/actions will be accomplished for those residents found to be by the practice Inadequate number of Certified Nursing Assistants How the facility will identify other residents having the potential to be affected by the deficient practice All the residents may be affected by the short staff as required by NJ DOH. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur? The Administrator will in-service the 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.	09/01/2025

Office of Primary Care and Health Systems Management

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S0560	<p>Continued from page 1</p> <p>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</p> <p>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.</p> <p>1. For the 2 weeks of Complaint staffing from 05/19/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows:</p> <p>-05/19/24 had 12 CNAs for 113 residents on the day shift, required at least 14 CNAs.</p> <p>-05/23/24 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs.</p> <p>-05/25/24 had 12 CNAs for 110 residents on the day shift, required at least 14 CNAs.</p> <p>-05/26/24 had 10 CNAs for 110 residents on the day shift, required at least 14 CNAs.</p> <p>2. For the 2 weeks of staffing prior to survey from 07/06/2025 to 07/19/2025, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows:</p> <p>-07/07/25 had 13 CNAs for 113 residents on the day shift, required at least 14 CNAs.</p> <p>-07/17/25 had 12 CNAs for 106 residents on the day shift, required at least 13 CNAs.</p>	S0560	<p>Continued from page 1</p> <p>The Administrator will boost the rate when there is an emergency staffing coverage.</p> <p>The staffing agency will block a schedule for the open position to cover the vacancies.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What Quality Assurance will be put in place</p> <p>The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 2 months.</p> <p>The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee which meets quarterly.</p> <p>Completion Date</p> <p>09-01-2025</p>	

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F0000	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 9/18/2025 in relation to the 7/24/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.</p>	F0000		

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 9/18/2025 in relation to the 7/24/2025 State of New Jersey Re-Licensure 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		

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K0000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/23/25 and the facility and 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 Occupancies.</p> <p>Complete Care at Woodlands is a two-story building constructed in 1998. It is composed of Type III (211) construction and has seven smoke compartments. The facility has a complete automatic sprinkler system (wet and dry). The diesel generator powers 50% of the building. The number of occupied beds was 106 out of 120.</p> <p>Delayed egress locks are installed at exit doors. Smoke detectors connected to the fire alarm system are installed in all patient rooms and throughout the corridors and other public spaces. Resident room doors have door closers installed that are held open by devices that release when the fire alarm is activated. There is no life support equipment.</p> <p>During the survey, a fire watch was implemented due to the water supply being cut off to the Dry System Riser #3 serving The Glen Wing and Rehab Area. The fire watch began on April 18th, 2025, after a leak was discovered. The repairs being made to the dry sprinkler system are scheduled for completion on July 29, 2025. The Glen and Rehab areas are only one story.</p>	K0000		08/08/2025
K0222 SS = F	<p>Egress Doors</p> <p>CFR(s): NFPA 101</p> <p>Egress Doors</p> <p>Doors in a required means of egress shall not be</p>	K0222	<p>KO 222 SS= F</p> <p>Life Safety Failed to meet the delayed egress locking requirements of NFPA 101 Life safety code. Delayed egress lock failed to unlock after 30 seconds of pressure applied on Glen Unit Stairwell.</p>	09/01/2025

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K0222 SS = F	<p>Continued from page 1 equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:</p> <p>CLINICAL NEEDS OR SECURITY THREAT LOCKING</p> <p>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p>SPECIAL NEEDS LOCKING ARRANGEMENTS</p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p>DELAYED-EGRESS LOCKING ARRANGEMENTS</p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</p>	K0222	<p>Continued from page 1 How will the corrective action be accomplished for those residents found to have been affected by the practice?</p> <p>Delayed egress locking device replaced/repaired by Maintenance Director to function properly opening within the 15 seconds as indicated after pressure was applied.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur?</p> <p>Center maintenance staff will be re-educated on safety health policy and procedures for ensuring center egress are functioning properly. Education provided by Regional Director od property Management.</p> <p>Maintenance Director will conduct daily walking rounds audit for 12 months to check egress locking devices are functioning in accordance to established safety standards.</p> <p>How will the Facility monitor its corrective actions to ensure that the deficient practice will not recur i.E what quality assurance program will be put into place</p> <p>Maintenance Director /designee will collect audit data and report to QAPI meeting monthly for 3 months or longer until Center achieves compliance.</p> <p>Time frame 09-01-2025</p> <p>Daily walking rounds</p> <p>Audit daily</p> <p>09</p> <p>10</p> <p>11</p>	

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K0222 SS = F	Continued from page 2 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to meet the delayed-egress locking requirements of NFPA 101 Life Safety Code (2012 Edition) Sections 19.2.2.2.4 and 7.2.1.6.1.1. This deficient practice had the potential to affect staff and 106 residents and was evidenced by the following: Observation on 07/23/25 at 10:15 AM of the designated exit door, located at the Stairwell by the Glen, revealed the delayed-egress lock failed to unlock after the US FOIA (b)(6) applied pressure to the release device for over 30 seconds. Signage on the door indicated an alarm would sound and that the locks would unlock after pressure was applied for 15 seconds, but neither occurred. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and revealed the facility was unaware the delayed egress lock was not functioning. NJAC 8:39-31.1(c), 31.2(e)	K0222	Continued from page 2 12 01 02 03 04 05 06 07 08	
K0352 SS = F	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain electronic	K0352	K0352 SS = F Sprinkler System – Supervisory Signals How the corrective action will be accomplished for those residents found to have been affected by the practice No negative outcome. Facility failed to maintain electronic supervision of sprinkler control valves as required by NFPA 101 (2012). Faulty monitor device will be replaced by contracted service provider. How the facility will identify other residents having the potential to be affected by the same deficient	09/01/2025

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K0352 SS = F	<p>Continued from page 3 supervision of sprinkler control valves as required by NFPA 101 (2012), Section 9.7.2.1 and NFPA 72, Section 9.7.2.1. This deficient practice had the potential to affect all 106 residents and was evidenced by the following:</p> <p>During an interview on 07/23/25 at 8:50 AM, the US FOIA (b)(6) stated the water supply had been cut off to the dry sprinkler system (Riser #3) serving the Glen Unit and Rehab.</p> <p>Observation on 07/23/25 at 9:55 AM of the fire alarm remote annunciator panel, located at the Nurses' Station in the Glen unit, revealed "System Normal." No supervisory signals were present indicating the water supply had been cut off to the sprinkler system.</p> <p>Observation on 07/23/25 at 11:30 AM of the dry sprinkler system (Riser #3), which served the Glen and Rehab Unit, revealed the control valve was positioned to cut off the water supply to the sprinkler system.</p> <p>During an interview on 07/23/25 at 6:30 PM, the US FOIA (b)(6) confirmed the finding and stated the facility had disconnected the tamper switch due to repairs being made to sprinkler piping.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25</p>	K0352	<p>Continued from page 3 practice</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur</p> <p>Education of Center staff on safety to maintain electronic supervision of sprinkler system control valves of fire alarm annunciator panel on Glen Unit in accordance with National Fire alarm Signaling Code NF 72 . Education provided by Regional Director of property Management.</p> <p>Maintenance Director / Designee will conduct weekly audit to ensure that a proper electrical signal indicator is functioning in accordance with safety practices. Weekly audit conducted monthly for 12 months.</p> <p>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</p> <p>Maintenance Director / Designee will conduct audit to ensure compliance. Collected data will be reported monthly for at quarterly QAPI to ensure compliance.</p> <p>Time frame 09-01-2025</p> <p>Functioning status</p> <p>2025</p> <p>09</p> <p>10</p> <p>11</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025
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K0352 SS = F		K0352	Continued from page 4 12 01 02 03 04 05 06 07 08 Weeks Clear Clear Testing	
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	K0353	K0353 SS = F Sprinkler System – Maintenance and Testing An impairment tag was not provided at the riser or at the fire Department connection as required by NFPA 25 (2011) How the corrective action will be accomplished for those residents found to have been affected by the practice	09/01/2025

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K0353 SS = F	<p>Continued from page 5</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</p> <p>9.7.5, 9.7.7, 9.7.8, and NFPA 25</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, record review, and interview, it was determined that 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). This deficient practice had the potential to affect staff and all 106 residents and was evidenced by the following:</p> <p>During an interview on 07/23/25 at 9:15 AM, the US FOIA (b)(6), stated the dry sprinkler system (Riser #3) serving the Glen Unit and Rehab was out of service due to corroded sprinkler piping that needed to be replaced. The system had been out of service since April 18, 2025, when a leak was discovered and water was shut off to the riser. The facility implemented a Fire Watch on April 18, 2025, which was still in place during the survey.</p> <p>Observation on 07/23/25 at 11:30 AM of the dry sprinkler system (Riser #3) serving the Glen and Rehab Unit revealed the water supply had been shut off. An impairment tag was not provided at the riser or at the Fire Department Connection as required by NFPA 25 (2011), Section 15.3.</p> <p>During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and stated the facility was unaware the impairment tag was missing from the riser prior to the survey.</p> <p>Review of the facility's sprinkler system records revealed the weekly inspections of the gauges for the dry sprinkler system were not conducted. This</p>	K0353	<p>Continued from page 5</p> <p>No negative outcome. Impairment tag was initiated to identify when system not functioning.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur</p> <p>Education to Center Maintenance / designee regarding safety to maintain Sprinkler system – in accordance to Maintenance Testing NFPA 25 standards. Tags will be implemented when system not functioning. Education provided by Regional Director of Property Management</p> <p>Maintenance Director / Designee will conduct weekly visual audit to ensure proper impairment tags are utilized as needed. Weekly visual inspection of gauges will be conducted for dry sprinkler system to ensure proper system is functioning in accordance too safety practices. Weekly audit data presented monthly.</p> <p>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</p> <p>Maintenance Director / Designee will conduct weekly audit to ensure compliance. Collected data will be reported monthly for three months at quarterly QAPI to ensure compliance.</p> <p>Time frame 09-01-2025</p> <p>Sprinkler system Testing Audit</p> <p>Status</p>	

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K0353 SS = F	Continued from page 6 documentation was requested on 07/23/25 at 9:00 AM, 12:15 PM, and 4:00 PM, but was not provided by the facility during the survey. During an interview on 07/23/25 at 4:00 PM, the US FOIA (b)(6) confirmed the finding and stated the facility was unable to provide documentation of the weekly inspections of the dry sprinkler system gauges during the survey. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K0353	Continued from page 6 09-2025 10-2025 11-2025 Visual inspection conducted Tag Identification Gauges functioning 09-01 no tag needed Visual inspection conducted Tag Identification Gauges functioning 09-08 no Tag needed Visual inspection conducted Tag Identification Gauges not functioning. Testing 09-15 No Tag Needed	
K0363 SS = F	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	K0363	K0363 SS= F Corridor Doors How the corrective action/actions will be accomplished for those residents found to have been affected by the practice The facility failed to ensure corridor doors closed and latched into frame without impediment and were constructed to resist passage of smoke in accordance with NFPA 101 Life Safety Code (2012). 45 residents were identified to be affected by the deficient practice. Soiled Linen Room, located by room [REDACTED] failed to close and latch in the door frame. Resident room [REDACTED] on the Glen Unit door failed to close and latch in the door frame. Resident room [REDACTED] on the Maplewood Unit door failed to close and latch in the door frame. Boiler Room on lower-level door failed to close and	09/01/2025

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K0363 SS = F	<p>Continued from page 7 of the doors. Hold open 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.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined that 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 45 residents and was evidenced by the following:</p> <p>An observation on 07/23/25 at 9:50 AM revealed the soiled utility room door, located in the corridor by Room [REDACTED] failed to close and latch in the door frame.</p> <p>An observation on 07/23/25 at 10:02 AM revealed the door of Room [REDACTED] failed to latch in the door frame.</p> <p>An observation on 07/23/25 at 10:31 AM revealed the door of Room [REDACTED] failed to latch in the door frame.</p> <p>Observation on 07/23/25 at 11:27 AM revealed the door to the boiler room, located in the corridor on the lower level, failed to latch in the door frame.</p> <p>During an interview at the time of the observations, the [REDACTED] confirmed the findings and stated the facility was unaware the doors were not closing and latching prior to the survey.</p> <p>NJAC 8:39-31.2(e)</p>	K0363	<p>Continued from page 7 latch in the door frame.</p> <p>All doors identified were repaired immediately to meet established smoke barrier code.</p> <p>How the facility will identify other residents having the potential to be affected by the deficient practice</p> <p>All residents have the potential to be affected by the same deficient practice.</p> <p>What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur?</p> <p>[REDACTED] / designee received education regarding proper corridor door enclosures to ensure doors are closing and latching property in accordance with Life safety code standards. Education provided by Regional Director of Property Management.</p> <p>Center Maintenance Director/ Designee will conduct door audit weekly for two months and then monthly for 12 months to ensure all doors are in accordance with safety Code.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What Quality Assurance will be put in place.</p> <p>Maintenance Director Designee will provide weekly audit results and results will be reviewed at monthly QAPI and quarterly meeting to ensure code compliance.</p> <p>Completion Date</p> <p>09-01-2025</p>	
K0372	Subdivision of Building Spaces - Smoke Barrie	K0372	Smoke Barrier	09/01/2025

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K0372 SS = F	<p>Continued from page 8</p> <p>CFR(s): NFPA 101</p> <p>Subdivision of Building Spaces - Smoke Barrier Construction</p> <p>2012 EXISTING</p> <p>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.</p> <p>19.3.7.3, 8.6.7.1(1)</p> <p>Describe any mechanical smoke control system in REMARKS.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, it was determined that the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6.2. This deficient practice had the potential to affect all 106 residents and was evidenced by the following:</p> <p>An observation on 07/23/25 at 10:08 AM of the smoke and fire barrier located at the Glen Unit, revealed a two-inch unsealed overcut around a wire penetration above the ceiling and smoke and fire doors.</p> <p>An observation on 07/23/25 at 11:06 AM of the smoke barrier located by Room [REDACTED] revealed a two-inch unsealed gap along the top of the wall at the metal deck.</p> <p>An observation on 07/23/25 at 11:09 AM of the smoke barrier located by Room [REDACTED] revealed a two-inch unsealed overcut around a group of wire penetrations above the ceiling and smoke doors.</p> <p>During an interview at the time of the observations, the [REDACTED] confirmed the findings and stated the facility was unaware of the unsealed gaps</p>	K0372	<p>Continued from page 8</p> <p>K0372 SS= F</p> <p>Smoke Barrier</p> <p>Facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous with NFPA 101 Life safety code (2012)</p> <p>How the corrective action/actions will be accomplished for those residents found to be by the practice</p> <p>Center Fire barriers identified as non-compliant were repaired immediately.</p> <p>Glen Unit, Room [REDACTED] and Room [REDACTED]</p> <p>How the facility will identify other residents having the potential to be affected by the deficient practice</p> <p>All residents have the potential to be affected by the same deficient practice.</p> <p>What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur?</p> <p>[REDACTED] / designee received education regarding proper smoke barrier maintenance without penetration. Education provided Regional Director of Property management.</p> <p>Center Maintenance Director/ Designee will conduct weekly smoke barrier audit rounds for two months and monthly rounds for six months to ensure smoke barriers do not have any penetration and are in accordance with Life Safety Code.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What Quality Assurance will be put in place.</p> <p>Maintenance Director / Designee audit results will be reviewed at monthly QAPI and quarterly meeting to ensure code compliance.</p> <p>Completion Date</p> <p>09-01-2025</p>	

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K0372 SS = F	Continued from page 9 and penetrations in the smoke barriers prior to the survey. NJAC 8:39-31.1(c), 31.2(e)	K0372		
K0918 SS = F	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) This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to provide a manual stop for the diesel generator in a remote location in accordance with NFPA 110 Emergency and Standby Systems (2010 Edition) 5.6.5.6. This deficient practice had the potential to affect all 106 residents and was evidenced by the following: An observation on 07/23/25 at 11:31 AM revealed there	K0918	K0918 SS = F Electrical Systems – essential Systems Maintenance and testing How the corrective action will be accomplished for those residents found to have been affected by the practice No negative outcome. Facility failed to provide a manual remote stop for a diesel generator in a remote location in accordance with NFPA 110 Emergency standard systems (2012). Manual stop for diesel generator in a remote location will be installed by contracted provider. 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. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur Education of US FOIA (b)(6) / Designee regarding Electrical Systems maintenance and testing in accordance with NFPA 110 emergency and standby systems (2010) Education provided by Regional Director of Property Management. Maintenance Director / Designee will conduct monthly audit for 12 months to ensure remote stop is installed and functioning properly. How the facility will monitor its corrective actions to	09/24/2025

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K0918 SS = F	Continued from page 10 was not a remote manual stop station installed for the Emergency Power System (EPS) on the premises where the prime mover was located outside of the building. The facility had a diesel generator located outside the building; however, a remote stop could not be located outside or inside the building. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the EPS did not have a remote manual stop located away from the diesel generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K0918	Continued from page 10 ensure that the deficient practice will not recur, i.e., what quality assurance program will be put into place Maintenance Director / Designee will conduct monthly audit to ensure compliance. Collected monthly data will be reported at quarterly QAPI to ensure compliance. Time frame 09-24-2025	
K0923 SS = F Bldg. 01	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K0923	K0923 Gas Equipment – Cylinder and container storage How the corrective action will be accomplished for those residents found to have been affected by the practice No negative outcome. Facility failed meet oxygen storage requirement of NFPA 99 Healthcare facilities Code (2012). Oxygen tanks were relocated from lower-level hallway to oxygen supply room. 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. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur Education regarding Gas Equipment Cylinder and Container storage to US FOIA (b)(6) / designee conducted. Education provided by Regional Director of Property Management.	09/01/2025

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K0923 SS = F Bldg. 01	<p>Continued from page 11</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, interview, and policy review, it was determined that the facility failed to meet the oxygen storage requirements of NFPA 99 Health Care Facilities Code (2012 Edition), Chapter 11. This deficient practice had the potential to affect staff and 35 residents and was evidenced by the following:</p> <p>Observations on 07/23/25 at 11:25 AM and 2:30 PM revealed 66 E Cylinders stored in the corridor by the Boiler Room and Kitchen. The oxygen cylinders were not in an enclosed interior space that was protected from unauthorized entry, were located within five feet of combustibles (cardboard boxes), and did not have the required signage (Empty, Full, and Precautionary).</p> <p>A review of the facility's oxygen safety policy revealed the cylinders "...shall be stored in an enclosed interior space of noncombustible or limited combustible construction, with doors and gates that can be secured against unauthorized entry..."</p> <p>During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and revealed the facility was aware the oxygen cylinders were stored there and needed to be moved.</p> <p>NJAC 8:39-31.2(e)</p> <p>NFPA 99</p>	K0923	<p>Continued from page 11</p> <p>Maintenance Director / Designee will conduct weekly audit rounds to ensure that proper Gas Equipment and cylinder container storage is maintained according to NFPA 99 Healthcare facilities code (2012).</p> <p>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</p> <p>Maintenance Director / Designee will conduct a weekly audit to ensure compliance. Collected data will be reported monthly and quarterly at QAPI meeting for two quarters to ensure compliance.</p> <p>Time frame 09-01-2025</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315273	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT WOODLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 WOODLAND AVE , PLAINFIELD, New Jersey, 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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 07/23/25. The facility was found to be in compliance with 42 CFR 483.73.	E0000		08/08/2025

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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/30/2025
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT WOODLANDS			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 WOODLAND AVE , PLAINFIELD, New Jersey, 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
K0000 Bldg. 01	<p>INITIAL COMMENTS</p> <p>An offsite/desk review of the facility's Plan of Correction was conducted on 9/30/2025 in relation to the X7/24/2025 Life Safety Code survey. The facility was found to be in compliance 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.</p>	K0000		

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
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