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 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WOODLANDS	**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
F0000	INITIAL COMMENTS Complaint #: 2667746 Census: 99 Sample Size: 3 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F0000		

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: 062022	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WOODLANDS	1400 WOODLAND AVE , PLAINFIELD, New Jersey, 07060

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S0000	Initial Comments Complaint #: 2667746 Census: 99 Sample Size: 3 The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long-Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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		
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 facility document review on (date) it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey for 1 of 14 day shifts from 11/9/2025 through 11/22/2025. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as 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:	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. Inservice provided 12-12-2025 •The Director of Human Resources will continue to post the vacancies on all 3 shifts. •The Director of Human Resources will schedule the Open	12/12/2025

Office of Primary Care and Health Systems Management

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S0560	Continued from page 1 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 of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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. The surveyor requested staffing for the weeks of 11/9/2025 and 11/16/2025.For the 2 weeks of 11/09/2025-11/26/2025 of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -11/17/2025 had 12 CNAs for 101 residents on the day shift, required at least 13 CNAs.	S0560	Continued from page 1 House. •The Administrator will boost the rate when there is an emergency staffing coverage. •The staffing agency will block a schedule for the open position to cover the vacancies. 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 •The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 2 months. The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee which meets quarterly. Completion Date 12-12-2025	

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F0000	INITIAL COMMENTS The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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.

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S0000	Initial Comments There is no Deficient Practice Statement for this citation.	S0000		
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: An offsite/desk review of the facility's Plan of Correction was conducted on 12/30/2025 in relation to the 11/26/2025 Complaint survey. There is no Deficient Practice Statement for this citation .	S0560		12/12/2025

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