STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315273	A. BUILDING _____ B. WING _____	C 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WOODLANDS	1400 WOODLAND 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 000	INITIAL COMMENTS Complaint #: NJ00175265 Survey Dates: 09/25/24 Census: 110 Sample Size: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential	F 842		10/23/24

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

Electronically Signed | 10/16/2024

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
	315273	A. BUILDING _____ B. WING _____	C 09/25/2024

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

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F 842	Continued From page 1	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(h)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WOODLANDS	1400 WOODLAND AVE PLAINFIELD, NJ 07060

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F 842	Continued From page 2 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint#: NJ00175265 Based on observation, interview, review of medical records and other pertinent facility documentation on 09/24/24 and 09/25/24, it was determined that the failed to maintain an accurate and complete medical record in accordance with acceptable standards and practice by not documenting a registered nurse's (RN) assessment of a resident that presented with a change in condition. The facility also failed to follow it's "Charting and Documentation" policy. This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed and was evidenced by the following: On 09/24/24, at 11:11 A.M., the surveyor observed the resident seated in a wheelchair beside the bed. The resident stated that staff was "sometimes" responsive to resident's needs. According to the facility "Admission Record", Resident #1 was admitted with diagnoses that included, but were 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 Order 26.4(b)(1)), NJ Ex Order 26.4 and NJ Ex Order 26.4(b)(1). The Quarterly Minimum Data Set (MDS), dated NJ Ex Order 26.4(b , an assessment tool used to facilitate the management of care revealed that Resident	F 842	Deficiency: F842 483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under 483.50. 1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Resident #1 was assessed and medical records were reviewed and no further concerns noted. One to one education provided to US FOIA and US FO who failed to document the assessment in the medical records. 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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	315273	A. BUILDING _____ B. WING _____	C 09/25/2024

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

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F 842	Continued From page 3 #1 had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated that the resident's cognition [redacted]. The surveyor reviewed Resident #1's progress notes which revealed the following: -On [redacted], at 10:27 P.M., a Licensed Practical Nurse (LPN) documented, "Resident [redacted] noted to [redacted] ..." -On [redacted], at 6:37 A.M., an LPN documented, "Resident was noted to have had [redacted] -On [redacted], at 3:47 P.M., an LPN documented, " ... resident [redacted] and [redacted]. [redacted] noted to [redacted] ..." A further review of the resident's progress notes failed to provide documented evidence that the resident was assessed by a registered nurse during any of the aforementioned days. On 09/24/24, at 3:06 P.M., the surveyor interviewed the [redacted] who stated that any change in a resident's condition should be reported by an [redacted] to an [redacted] She further stated that episodes of [redacted] were each considered a change in a resident's condition that should have been reported to the [redacted] on the unit and who then should assess the resident. The [redacted] further stated that she recalled the aforementioned dates and that she	F 842	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 collecting data and documenting in residents' charts. DON/designee will ensure nurses report to the RN Unit Manager or RN Supervisor when a change in condition occurs for immediate follow up and physician to be notified. 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/Designees will conduct daily chart audits of all change in conditions weekly x 4 weeks, then monthly x 2 months. Results of these findings will be presented to the Administrator at the QAPI meeting, which is held quarterly. Date of Compliance: 10-23-2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315273	A. BUILDING _____ B. WING _____	C 09/25/2024

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

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F 842	Continued From page 4 did assess the resident during that time period. She further stated that she could not recall why she did not document her assessments, but that she should have. On 09/25/24, at 1:05 P.M., the surveyor interviewed the U.S. FOIA (b) (6)) who stated that her expectation is that any change in a resident's condition that is noted by an US FOIA should be reported to an U.S. FOI who should then verify the data and document it. The surveyor reviewed the facility's "Charting and Documentation," policy, revised January 2023, revealed that all services provided to the resident were to be documented in the medical record. The "Policy Interpretation and Implementation" section revealed a list of information was that was to be documented in the medical record including, " ... d. Changes in the resident's condition ..." NJAC 8:39-27.1(a)	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062022	A. BUILDING: _____ B. WING _____	C 09/25/2024

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

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each 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 (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 3 day shifts. 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	S 560	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	10/23/24

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

Electronically Signed | 10/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062022	A. BUILDING: _____ B. WING _____	C 09/25/2024

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S 560	Continued From page 1 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 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. 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 3 of 14 day shifts as follows: -05/19/24 had 13 CNAs for 113 residents on the day shift, required at least 14 CNAs. -05/25/24 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs. -05/26/24 had 13 CNAs for 110 residents on the day shift, required at least 14 CNAs.	S 560	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 Open House to fill open positions. • 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 3 months. The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee. Completion Date 10-23-2024	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315273	A. Building B. Wing	10/23/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WOODLANDS	1400 WOODLAND 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 F0842 Reg. # 483.20(f)(5), 483.70(h)(1)-(5) LSC	Correction Completed 10/23/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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
9/25/2024

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
062022		10/23/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WOODLANDS	1400 WOODLAND 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 Reg. # 8:39-5.1(a) LSC	Correction Completed 10/23/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
9/25/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO