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 02/01/2024

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 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 01/29/24 to 02/01/24 Survey Census: 115 Sample Size: 27 Supplemental Residents: 10 No deficiencies were issued related to Intake NJ165015.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis,	F 550		2/22/24

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

Electronically Signed | 02/22/2024

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F 550	Continued From page 1 severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to provide one of 27 sampled residents (Resident (R) 87) a dignified dining experience. Specifically, the facility failed to provide regular silverware to R87, NJ Exec Order 26.4b1 [redacted]. Findings include: During an observation on 01/29/24 at 12:28 PM, R87 was in bed with [redacted] lunch tray in front of [redacted] R87 was using plastic silverware to eat. When interviewed, R87 stated [redacted] did not know why [redacted] was provided plastic utensils to eat [redacted] meal.	F 550	F550 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE Resident R87 was given non-disposable silverware for all meals. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE	

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F 550	Continued From page 2 During an observation on 01/30/24 at 9:58 AM, R87 was in bed with [NJ Ex 0] breakfast tray in front of [NJ Ex 0]. R87 stated "[NJ Exec Order 26.4b1]." The resident had [NJ Exec Order 26.4b1] of [NJ Ex 0] meal using plastic utensils. When interviewed, R87 stated, "I've never had anything but plastic. . ." During an observation on 01/30/24 at 12:07 PM, R87 was in bed with [NJ Ex 0] lunch tray in front of [NJ Ex 0]. R87 had plastic utensils provided to eat [NJ Ex 0] meal. When interviewed, R87 stated, [NJ Exec Order 26.4b1] " During an observation on 01/31/24 at 8:23 AM, R87 was in bed with [NJ Ex 0] breakfast tray in front of [NJ Ex 0] R87 stated "look, I don't know how I got them." R87 was observed pointing at the silverware on [NJ Ex 0] tray. When interviewed, R87 stated, "it's much easier to eat with these than plastic." During an observation on 02/01/24 at 8:32 AM, R87 was observed to have regular silverware on [NJ Ex 0] breakfast tray. R87 stated, "[NJ Exec Order 26.4b1] " Review of R87's "Census" located under the "Clinical" tab in the electronic medical record (EMR) revealed R87 was admitted on [NJ Exec Order 26.4] with diagnoses that included [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] following [NJ Exec Order 26.4b1] affecting [NJ Exec Order 26.4b1] Review of R87's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4] revealed a "Brief Interview for Mental Status (BIMS)" score of [NJ Ex] out of 15	F 550	[NJ Exec Order 26.4b1] to resident R87. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR 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 DON/designee educated all staff on Resident Rights, and dignity. DON/designee educated the interdisciplinary team on care plan review and updating as needed. 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 review quarterly care plan meetings to ensure resident care plans reflect their plan of care and are updated accordingly weekly x 4 weeks then monthly x 3. DON/designee will collect data and report to monthly QAPI for 3 months or longer,	

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F 550	Continued From page 3	F 550	until center has established compliance.	

indicating R87 was NJ Exec Order 26.4b1. Review of the Mood and Behavior sections noted NJ Exec [redacted]" and NJ Exec Order 26.4b1 [redacted]."

Review of nurses' progress notes, located in the EMR "Clinical" tab and dated NJ Exec Order 26.4 [redacted], revealed R87 "is NJ Exec Order 26.4b1 [redacted] noted. All medications given as ordered, NJ Exec Order 26.4b1 noted. NJ Exec Order [redacted]"

Review of the NJ Exec Order 26.4 [redacted] NJ Exec Order 26.4b1 Notes,: located under the EMR "Miscellaneous" tab, revealed "NJ Exec Order 26.4b1 [redacted] req.[requested] . . . S/P [status post] Hosp [hospital] NJ Exec Order 26.4b1). Per records resident NJ Exec Order 26.4b1 during hosp stay-NJ Exec Order 26.4b1 Nursing staff report NJ Exec [redacted] NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 being in facility. NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1. NJ Exec Order 26.4b1. NJ Exec Order 26.4b1 [redacted] NJ Exec Order 26.4b1." Plan noted "Monitor & Document Resident's NJ Exec Orde & NJ Exec Order 26.4b1 Report any concerns to NJ Exec Order 26.4b1"

Review of "Individual NJ Exec Order 26.4b1 progress notes," located and the EMR "Miscellaneous" tab, dated NJ Exec Order 26.4b [redacted], NJ Exec Order 26.4b [redacted], NJ Exec Order 26.4 [redacted], NJ Exec Order 26.4b [redacted] revealed NJ Exec Order 26.4b1

Review of the "NJ Exec Order 26.4b1" logs, provided by the facility, beginning at 5:00 PM on NJ Exec Order 26.4 [redacted] to 3:00 PM on NJ Exec Order 26.4 [redacted] revealed "NJ Ex

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F 550	Continued From page 4 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 in place for NJ Exec Order 26.4b1 Review of R87's care plan, revised on NJ Exec Order 26.4b and located under the "Clinical" tab, revealed R87 did not have an NJ Exec Order 26.4b1 for plastic utensils. During an interview on 01/31/24 at 11:13 AM, the U.S. FOIA (b) (6)) stated she did not know why R87 was served NJ Ex O meals with plastic utensils. During an interview on 01/31/24 at 2:04 PM, the U.S. FOIA (b) (6)) stated, "when the resident first came in NJ Exec Order 26.4b1, nurses told dietary no silverware, never told anything different." During an interview on 02/01/24 at 8:46 AM, Unit Manager (UM) 1 said she did not know that R87 was served with plastic utensils, 'NJ Exec Order 26.4b1 " Review of the facility's "Suicide Assessment" policy and procedure, provided by the U.S. FOIA (b) (6) , dated 01/10/23, revealed "Residents will be assessed for suicide risk upon admission and as indicated. The facility social worker or designee will conduct a medical record review and then interview the resident regarding any risk factors that have been identified. Protective factors will be explored with the resident as well."	F 550		
F 640 SS=E	NJAC 8:39-17.2 Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)	F 640		2/28/24

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F 640	Continued From page 5 §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		

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F 640	Continued From page 6 (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, interview, review of the Resident Assessment Instrument (RAI) manual and policy review, the facility failed to ensure ten residents out of 27 sampled resident's (Resident (R)16, R62, R6, R42, R44, R97, R72, R78, R2, R15) "Minimum Data Set (MDS)" assessments were transmitted in a timely manner. Findings include. Review of the facility policy titled, "MDS Completion and Submission Timeframes," dated 10/22/23, revealed, ". . . Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes . . . The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS [Center for Medicare/Medicaid Services] QIES [Quality Improvement & Evaluation System] Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines . . . Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual . . ." Review of the "CMS Long-term Facility	F 640	Encoding/Transmitting Resident Assessments, F 640 SS=E Corrective action(s) accomplished for resident(s) affected: Facility failed to ensure ten residents out of 27 sampled residents (Resident (R)16, R62, R6, R42, R44, R97, R72, R78, R2, R15) "Minimum Data Set (MDS)" assessments were transmitted in a timely manner. Residents identified having the potential to be affected and corrective action taken: All residents have the potential to be affected by this deficient practice. Measures will be put into place to ensure the deficient practice will not recur: US FOIA (b)(6) was educated by regional MDS nurse regarding MDS transmission process on timely manner. MDS will increase transmission 3 times a week to CMS to avoid late submission. A full audit was completed on the transmission process with no further errors noted on MDS. Corrective actions will be monitored to ensure the deficient practice will not recur: Regional MDS/designee will audit random	

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F 640	Continued From page 7 Assessment Instrument 3.0 User's Manual," version 1.18.11, dated 10/23/23, revealed, " . . . Chapter 2: Assessments for the Resident Assessment Instrument, 2.6: Required OBRA Assessments for the MDS . . . RAI OBRA [Omnibus Budget Reconciliation Act]-required assessment summary for quarterly, significant change, and annual, and discharge assessments are no later than ARD [assessment reference date] + 14 calendar days . . ." 1. Review of the annual "MDS," located in the "MDS" tab of the electronic medical record (EMR), with an ARD date of [redacted] revealed R16 was admitted to the facility on [redacted]. On [redacted], the assessment was identified to be "export ready" and was to be submitted by [redacted] The assessment was 10 days late in being submitted. 2. Review of the quarterly "MDS" located in the "MDS" tab of the EMR with an ARD of [redacted] revealed R62 was admitted to the facility on [redacted]. On [redacted], the assessment was identified to be "export ready" and should have been submitted on [redacted]. The assessment was 12 days late in being submitted. 3. Review of the quarterly "MDS" located in the "MDS" tab of the EMR with an ARD of [redacted] revealed R6 was admitted to the facility on [redacted]. On [redacted] the assessment was identified to be submitted 14 days late on [redacted] and should have been submitted on [redacted]. 4. Review of the quarterly "MDS" located in the "MDS" tab of the EMR with an ARD of [redacted] revealed R42 was admitted to the facility on	F 640	10 residents completed MDS for accuracy weekly 4 weeks and monthly x 2. The results of the findings will be reported to the Administrator at the quarterly QAPI meeting.	

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F 640	Continued From page 8	F 640		

NJ Exec Order 26.4b. On NJ Exec Order 26.4b, the assessment was identified to be "in progress." The assessment should have been submitted on NJ Exec Order 26.4b. The assessment was 23 days late in being submitted.

5. Review of the annual "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26.4 revealed R44 admitted to the facility on NJ Exec Order 26.4b. On NJ Exec Order 26.4b, the annual "MDS" was identified to be "in progress." The assessment should have been submitted on NJ Exec Order 26.4b. The assessment was 26 days late in being submitted.

6. Review of the quarterly "MDS" located in the "MDS" tab of the EMR with ARD of NJ Exec Order 26.4 revealed R97 was admitted to the facility on NJ Exec Order 26.4b. On NJ Exec Order 26.4b1 the quarterly "MDS was identified to be "export ready" and was to be submitted by NJ Exec Order 26.4b. The assessment was 10 days late in being submitted.

7. Review of the significant change "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26.4b, revealed R72 was admitted to the facility on NJ Exec Order 26.4b. On NJ Exec Order 26.4b, the assessment was identified to be "export ready" and was to be submitted by NJ Exec Order 26.4b. The assessment was 11 days late in being submitted.

8. Review of the annual "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26.4 revealed R78 was admitted to the facility on NJ Exec Order 26.4b. On NJ Exec Order 26.4b, the assessment was identified to be "export ready" and was to be submitted by NJ Exec Order 26.4b. The assessment was six days late in being submitted.

9. Review of the annual "MDS" located in the "MDS" tab of the EMR with an ARD of NJ Exec Order 26.4

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F 640	Continued From page 9 revealed R2 was admitted to the facility on [NJ Exec Order 26.4b]. On [NJ Exec Order 26.4b], the assessment was identified to be "export ready" and was to be submitted by [NJ Exec Order 26.4b]. The assessment was four days late in being submitted. 10. Review of the significant change "MDS" located in the "MDS" tab of the EMR with an ARD of [NJ Exec Order 26.4b] revealed R15 was admitted to the facility on [NJ Exec Order 26.4b]. On [NJ Exec Order 26.4b], the assessment was to "export ready" and was to be submitted on [NJ Exec Order 26.4b]. The assessment was three days late in being submitted. During an interview on 01/31/24 at 8:37 AM, the [U.S. FOIA (b) (6)]) was asked why the assessments were not submitted in a timely manner. She stated, "I am the only one doing "MDS" assessments. I know they are not submitted but I have been waiting on social services as they have not been able to input their information timely."	F 640		
F 655 SS=E	NJAC 8:39-11.2(3) Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's	F 655		2/28/24

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F 655	Continued From page 10 admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review, the facility failed to develop a baseline care plan for five of 27 residents (Resident (R) 159, R109, R160, 45, and R32) to include interventions to address current	F 655	F655 SS=E HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE	

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F 655	Continued From page 11 resident needs. Findings include: 1. Review of R159's "Census," located in the electronic medical record (EMR) under the "Clinical" tab, revealed R159 was admitted to the facility on NJ Exec Order 26.4b and had diagnoses that included NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1, NJ Exec Order 26 NJ Exec Order 26.4b1 of NJ Exec Order 2 NJ Exec Order 26 NJ Exec Order 26.4b1 of NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 ; NJ Exec Order 26.4b1 of other part of NJ Exec Order 26.4b with NJ Exec Order 26.4b1. During an observation on 01/29/24 at 12:46 PM, R159 was lying NJ Exec Order 26.4b1. R159 appeared NJ Exec and NJ Exec Order 26.4b1 When interviewed, R159 stated, NJ Exec Order 26.4b1 " R159 was observed to NJ Exec Order 26.4b1 R159 was NJ Exec Order 26.4b1. During an observation on 01/30/24 at 9:58 AM, R159 was asleep in bed. R159's NJ Exec Order 26.4b was observed to have NJ Exec Order 26.4b1 on. During an observation on 01/31/24 at 8:31 AM, R159 was in bed and stated, NJ Exec Order 26.4b1." Unit Manager (UM) 1 was assisting R159 to take NJ Exec O . R159 was observed to say, " NJ Exec O and NJ Exec Order 26.4b1 R159's NJ Exec Order 26.4 was observed NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 were noted, NJ Exec Order 26.4b1. The UM1 stated, NJ Exec Order 26.4b1 Review of R159's baseline care plan, initiated	F 655	RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE R159 care plan meeting was conducted. R109 care plan meeting was conducted. R160 care plan meeting was conducted. R45 care plan meeting was conducted. R32 care plan meeting was conducted. NJ Exec Order 26.4b1 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 IDT/nursing staff educated by DON/designee on Care Plans—Baseline and Comprehensive Care Plan DON/designee will audit all new admissions and readmissions for baseline care plans completion within 48 hours of admission from 2/19 forward. HOW THE FACILITY WILL MONITOR	

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	315273	A. BUILDING _____ B. WING _____	C 02/01/2024

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F 655	Continued From page 12 NJ Exec Order 26.4b, revealed "focus" areas identified as: NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 history of NJ Exec Order 2 use of NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 due to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1; NJ Exec Order 26.4b1 related to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. There was not a "focus" concern to address R159's NJ Exec O and NJ Exec Order 26.4b1 due to the NJ Exec Order 26.4b1 and NJ Exec O During an interview on 02/01/24 at 12:48 PM with the U.S. FOIA (b) (6)) and UM1, the U.S. FOIA stated, "it is our expectation that NJ Exec O would be on the baseline care plan." 2. Review of R109's "Census" located in the EMR under the "Clinical" tab revealed R109 was admitted to the facility on NJ Exec Order 26.4b and had diagnoses that included NJ Exec Order 26.4b1 During an observation on 01/29/24 at 12:56 PM, R109 was in NJ Ex O room seated in NJ Ex O wheelchair while Family Member (F4) assisted to eat a dessert. F4 stated, NJ Exec Order 26.4b1 F4 touched R109's NJ Exec Order 26.4b1 R109 said, " NJ Exec Order 2 ," and NJ Exec Orde . Review of R109's baseline care plan, initiated NJ Exec Order 26.4b, revealed "focus" areas identified as: dependent on staff for meeting NJ Exec Order 26.4b1	F 655	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 monitor new admissions Baseline Care Plan weekly X 4 weeks then monthly X 3 months and document findings on audit tool. DON/designee will collect data and report to monthly QAPI for 3 months or longer, until center has established compliance.	

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NJ Exec Order 26.4b1 related to resident has a NJ Exec Order 26.4b1; at ; and resident has NJ Exec Order 26.4b1 There was not a "focus" concern to address R109's NJ Exec Order 26.4b1 or R109's NJ Exec Order 26.4b1.

In an interview on 02/01/24 at 12:48 PM with the and UM1, the stated, "it is our expectation that and NJ Exec Order 26.4b1 would be on the baseline care plan."

3. Review of R160's "Census" located in the EMR under the "Clinical" tab revealed R160 was admitted to the facility on and had diagnoses that included NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1

During an observation on 01/29/24 at 12:30 PM, R160 was in room in wheelchair with lunch tray in front of her. R109 NJ Exec Order 26.4b1

During an observation on 01/31/24 at 8:28 AM, R160 was sitting upright in bed with breakfast tray in front of . R160 pointed to orange juice and smiled, pointed to plate, and shook head " and placed hand on .

Review of R160's baseline care plan, initiated on , revealed "focus" areas identified as: NJ Exec Order 26.4b1 for meeting and needs; resident has NJ Exec Order 26.4b1; resident

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F 655	Continued From page 14	F 655		

has an NJ Exec Order 26.4b1 ; at NJ Exec related to NJ Exec Order 26.4b1. There was not a "focus" concern to address R160's NJ Exec or R160's NJ Exec Order 26.4b1 needs.

During an interview on 01/31/24 at 1:25 PM, R160 (with R160's three Family Members (F1, F2, and F3) NJ Exec Order 26.4b1, stated NJ Ex had NJ Exec Order 26.4b1 and confirmed that had NJ Exec Order 26.4b1 in her NJ Exec . R160 did not state that had any NJ Exec at the time of the interview, however, did confirm that NJ Ex has had NJ Exec from the NJ Exec Order 26 and NJ Exec Order 26

In an interview on 02/01/24 at 12:48 PM with the U.S. FOIA and UM1, the U.S. FOIA stated, "it is our expectation that NJ Exec and NJ Exec Order 26.4b1 would be on the baseline care plan."

4. Review of the undated "Admission Record" under the "Profile" tab in the EMR revealed R45 was admitted to the facility on NJ Exec Order 26.4 with the diagnosis of NJ Exec Order 26.4b1

Review of R45's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of NJ Exec Order 26.4 coded the resident of having a "Brief Interview for Mental Status (BIMS)" score of NJ Exec Or out of a possible score of 15. This represents R45 was severely NJ Exec Order 26.4b1

Review of R45's EMR revealed the resident did not have a base line care plan developed within 48 hours of admission to the facility. R45 was admitted on NJ Exec Order 26.4.

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During an interview on 02/01/24 at 1:11 PM, UM1 reviewed the EMR and stated, "There isn't a base line care plan that was started for [R45] . . . We have a care plan meeting, but it is done when they are here for 72 hours."

5. Review of the undated "Admission Record" under the "Profile" tab in the EMR revealed R32 was admitted to the facility on [redacted] with the diagnosis of NJ Exec Order 26.4b1 [redacted].

Review of R32's "Admission Assessment" under the "Evaluation" tab located in the EMR revealed R32 was [redacted] and [redacted] The admission "MDS" was not completed at that time of the survey.

Review of R32's EMR revealed the resident did not have a base line care plan developed within 48 hours of admission to the facility. R32 was admitted on [redacted].

During an interview on 02/01/24 at 10:01 AM, UM2 stated, "I only do care plans. I have never heard of giving this to the resident or [responsible party]. How would I know the regulations? We usually have a care plan meeting within 72 hours that we go over this with them." UM2 verbally confirmed R32 did not have a baseline care plan.

Review of the facility policy "Baseline Care Plan" dated 10/02/23 revealed, "The facility will develop and implement a baseline care plan for each resident that includes the instructions, needed to provide effective and person-centered care of the resident that meet professional standards of quality care." ". . .The baseline care plan will be . .

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F 655	Continued From page 16 . developed within 48 hours of a resident's admission . . . A supervising nurse will verify within 48 hours that a baseline care plan has been developed . . . A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand . . . A supervising nurse or MDS [Minimum Data Set] nurse/designee is responsible for providing the written summary of the baseline care plan to the resident and representative . . . The person providing the written summary of the baseline care plan shall . . . Obtain a signature from the resident/representative to verify that the summary was provided . . . Make a copy for the medical record. If the summary was provided via [by] telephone, the nurse shall indicate the discussion, sign the summary document, and make a copy of the written summary before mailing the summary to the resident/representative . . ." NJAC 8:39-11.1 NJAC 8:39-11.2	F 655		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility staff failed to follow professional standards of practice and left medications at the bedside that were not ordered to be NJ Ex Order 26.4(b)(1) for one of one resident	F 658	F658 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE	2/28/24

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F 658	Continued From page 17 (Resident (R) 98). Findings include: Review of the undated "Admission Record" under the "Profile" tab in the electronic medical record (EMR) revealed R98 was admitted to the facility on NJ Exec Order 26.4b with the diagnosis of NJ Exec Order 26.4b1 [redacted]. Review of R98's admission "Minimum Data Set" (MDS) with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b coded the resident of having a "Brief Interview for Mental Status" (BIMS) score of NJ Ex out of a possible score of 15. This represented R98 was NJ Exec Order 26.4b1 An observation was made on 01/31/24 at 9:38 AM in which Registered Nurse (RN)1 was walking out of R98's room. On the overbed table, there were two pills in a medicine cup left. RN1 returned to R98's room after five minutes and stated, "One of those pills is his NJ Exec Order 26.4b1 and the other one is his NJ Exec Order 26.4b1 [redacted] RN1 then stated, "I should not have left the room." During an interview on 01/31/24 at 3:00 PM, the U.S. FOIA (b) (6)) stated, "Nurses are not to leave any medications unattended in the resident's room unless they are self-administrated medications." Review of R98's "Physician Orders" under the "Orders" tab located in the EMR revealed orders for NJ Exec Order 26.4b and three NJ Exec Order 26.4b1 were not NJ Exec Order 26.4b1 .	F 658	RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE 1:1 education provided to RN1 who left medication on the resident's over bed table. NJ Exec Order 26.4b1 to R98 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 DON/designee reeducated all nursing staff on Professional Standards when Administering Medications. One on one reeducation to RN1 on Professional Standards when Administering Medications. 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	

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F 658	Continued From page 18 NJAC 8:39-29.2(2)	F 658	DON/designee will conduct Medication Administration audits weekly X 4 weeks then monthly X 3 months and document findings on audit tool. DON/designee will collect data and report to monthly QAPI for 3 months or longer, until center has established compliance.	
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.	F 660		2/28/24

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(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.
(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge

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F 660	Continued From page 20 needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and policy review, the facility failed to ensure a safe discharge for residents that left Against Medical Advice by ensuring agencies in the community were made aware the resident was returning to the community prior to a planned discharge and that prescriptions for care and medications were provided to ensure continuity of care for two of two (Resident (R) 107 and R105) residents reviewed for NJ Exec Order 26.4b1 discharge. Findings include: 1. Review of R107's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed [redacted] was admitted to the facility on NJ Exec Order 26.4b with diagnoses including NJ Exec Order 26.4b1 [redacted] Review of R107's admission "Minimum Data Set (MDS)" assessment, located under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b revealed [redacted] scored [redacted] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating NJ Exec Order 26.4b1 . Review of R107's care plan, located under the	F 660	F660 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE R107 – No longer resides in the facility. R105 – No longer resides in the facility. 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 IDT/nursing staff educated by DON/designee on Policy and Procedure on Voluntary Discharge Against Medical Advice	

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F 660	Continued From page 21 "Care Plan" tab of the EMR and dated NJ Exec Order 26.4b, revealed R107 was care planned for NJ Exec Order 26.4b1 [redacted] Interventions in place were to administer NJ Exec Order 26.4b1 medications as ordered and monitor, and NJ Exec Order 2 [redacted] Review of R107's NJ Exec Order 26.4b1 [redacted]," located under the "Observations" tab in the EMR and dated NJ Exec Order 26.4 at 3:25 PM, revealed unit manager (UM) 1 signed the form stating that R107 NJ Exec Order 26. to sign. Review of R107's physician orders, located under the "Orders" tab in the EMR and dated NJ Exec Order 26.4, revealed NJ Exec Order 26.4b1 to keep NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 veryday day shift for NJ Exec Order care, NJ Exec Order 26.4b1 every 12 hours as needed for NJ Exec Order 26 NJ Exec Order 26.4b1 once a day for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 once daily for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 every 8 hours for NJ Exec Order 26.4b1. Review of R107's "Nurse's Note," located under the "Notes" tab in the EMR and dated NJ Exec Order 26.4 at 4:14 PM, by Licensed Practical Nurse (LPN) 2 revealed R107 left the facility NJ Exec Or NJ Ex Ord was NJ Exec O and NJ Exec Order 26.4b1 and able to NJ Exec Order 26.4b1 and was in NJ Exec Order 26.4b1 while leaving the facility. Further review of the EMR "Notes" tab lacked evidence of discharge planning or discussions of R107's discharge. During an interview on 01/31/24 at 9:11 AM,	F 660	The facility will conduct an audit of all residents who discharged against medical advice within the past 30 days. 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 audits on all residents who Voluntary Discharge Against Medical Advice weekly X 4 weeks then monthly X 3 months and document findings on audit tool. DON/designee will collect data and report to monthly QAPI for 3 months or longer, until Center has established compliance.	

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LPN2 stated when a resident wanted to leave NJ Exec Order 26.4b1 staff notified the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6)). LPN2 was unsure if staff were to make these notifications before the resident actually left the building. LPN2 stated staff would speak with the resident and ask them why or what reason led them to want to leave; they should be offered the voluntary discharge form to sign and if they refuse that would have been documented. LPN2 stated the physician should have been notified while the resident was still in the building and the family would have been made aware. LPN2 stated social services along with the physician would have attempted to talk with the resident and make them aware what NJ Exec O meant and how it would have NJ Exec Order 26.4b1 . LPN2 stated if there was any NJ Exec Order 26.4b or NJ Exec Order 26.4b care staff would provide the care before the resident left the building if the resident allowed. LPN2 stated R107's family was here with NJ Ex O, and NJ Ex O NJ Exec Order 26.4b1 and NJ Exec Order care was also provided prior to R107 leaving but she did not document that. LPN2 stated she made UM1 along with the U.S. FOIA (b) (6)) aware and that one of them should have contacted the physician.

During an interview on 01/31/24 at 10:20 AM, UM1 stated when a resident requests to leave NJ Exec O the team would try to find out why and would notify the physician, family and any other department that was providing care to the resident. UM1 stated staff would have tried to talk to the resident to get them to reconsider and remain in the facility. UM1 stated there was an NJ Exec O form that most residents refused to sign but NJ Exec O did not happen very often. UM1 stated all notifications should have been documented in the

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progress notes and if the [redacted] form was signed or if the resident refused. UM1 stated while R107 was in the facility [redacted] and was [redacted]; and R107 [redacted] UM1 stated R107 was always [redacted] but was unsure if that was ever reported to social services or to anyone else to follow up with the resident. UM1 stated staff should have been proactive and spoke to R107 to see if there was something that could have [redacted] with [redacted] care prior to [redacted] and that all the notifications should have been documented in progress notes. UM1 confirmed there was no documentation of the notifications. She did not remember anything about R107 leaving [redacted]

During an interview on 01/31/24 at 10:40 AM, the [redacted] stated when a resident [redacted] staff would try to [redacted]. The [redacted] stated they explain what leaving [redacted] means so the resident can give informed consent and are aware of the possible [redacted]. The [redacted] stated that was only for a resident with a higher BIMS who would be able to [redacted] would be too low, and that person would not be considered [redacted] and staff would have to call next their next of kin. The [redacted] stated [redacted] could have gotten a referral to have a visiting nurse agency (VNA) in the community, but the agency would not accept referrals for residents that [redacted] The [redacted] stated if the resident's family was on the ball and there was no concern, they may not call adult protective services (APS) because they would not get involved unless there was

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established neglect and not just if there was a potential for neglect. The U.S. FOIA stated R107 was a NJ Exec Order 26.4b1 who NJ Exec Order 26.4b1. The U.S. FOIA stated R107 had a NJ Exec Order 26.4b1 with NJ Ex O NJ Exec Order 26.4b1 who visited the facility often. The U.S. FOIA stated one day R107 decided NJ Exec Order 26.4b1 The U.S. FOIA stated she looked into trying to get NJ Exec Order 26.4b1 and told NJ Ex Order 26.4 needed an aide in the home to make it a safe discharge. The U.S. FOIA stated she found an agency that would have provided an aide in the home if R107 signed the form, but she did not have any documentation of that. The U.S. FOIA stated on the day R107 NJ Exec Order 26.4 she called the resident's NJ Exec and set up transportation who came and transported R107 home. The U.S. FOIA stated she did not follow up with R107 in the community after NJ Ex O left, but she thought it was a questionable situation of R107 NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The U.S. FOIA stated she felt R107 NJ Exec Order 26.4b1 NJ Ex O had a responsible family who she felt would contact the facility if there were any issues in the community. The U.S. FOIA stated that all the information should have been documented but she was busy and could not always get to it.

During an interview on 01/31/24 at 12:03 PM, R107 stated it NJ Exec Order 26.4b1 and that NJ Ex O case worker wanted NJ Ex O to sign something to stay at the facility, but NJ Ex O did not have on NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 the form. R107 stated the facility had a cab or an uber take NJ Ex O home because NJ Ex O did not pay for it. R107 stated NJ Ex O had NJ Ex O house keys and the driver who transported NJ Ex O helped NJ Ex O NJ Exec Order 26.4b1 because NJ Ex O went NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. R107 stated none of NJ Ex O family were with NJ Ex O at the facility to escort NJ Ex O home the day NJ Ex Order 26.4. R107

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stated nobody explained what the form was that [NJ Ex Or] was asked to sign or offered to read it to [NJ Ex Or] R107 stated [NJ Ex Or] would not sign anything [NJ Ex O] was unable to read. R107 stated staff did not call [NJ Ex O] family and did not have to provide [NJ Ex O] with any prescriptions for any of [NJ Ex O] medications or supplies for [NJ Ex OrNJ Exec Order] care.

During an interview on 01/31/24 at 12:10 PM, Physician 1 said anytime a resident wanted to [NJ Exec Order 26.4b1] staff should inform her and that most times it was because the [NJ Exec Order 26.4b1] with the facility about their care. Physician 1 could not remember why R107 wanted to leave or what happened and did not remember the specifics of R107 [NJ Exec Order 26.4b1]. Physician 1 was unsure if she instructed staff to do anything for R107 or if she spoke with the resident and she would need to look at her records and get back.

During a follow-up call on 01/31/24 at 12:52 PM, Physician 1 stated she remembered R107 told her [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] for discharge. Physician 1 recalled she told R107 she would [NJ Exec Order 26.4b1] and social services to see about setting a discharge date. Physician 1 stated a few days later, [NJ Exec Order 26.4] at 3:51 PM, she was told by staff via text that R107 wanted to [NJ Exec Or] Physician 1 stated any residents who went [NJ Exec O] who received [NJ Exec Order] care would have been provided a prescription for the [NJ Exec Order] care supplies along with a 30 prescription for all regular prescriptions and a 5-day prescription for any [NJ Exec Order 26] medications and a script for home nursing services. Physician 1 was unsure why that was not provided to R107 and stated she thought R107 just walked out of the facility but stated they can call in the prescriptions to the pharmacy. Physician 1 stated she thought the

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facility did not have time to provide the scripts to R107 because she thought R107 just walked out. Physician 1 was unable to state why the facility did not ensure R107 was provided with scripts for [redacted] medications and [redacted] care supplies. Physician 1 stated again she thought R107 just up and left. When she was informed the [redacted] was signed as refusing at 3:25 PM but she was not notified by staff until 3:51 PM almost 30 min later, she said she would have expected to be notified timely but would not say if the facility was right or wrong. And again, said R107 was not provided with any scripts for any of [redacted] medications, [redacted] care, or a home health nurse.

During an interview on 02/01/24 at 1:07 PM, the [redacted]) stated when a resident wanted to [redacted] staff would try and encourage the resident to stay and educate them on what [redacted] meant. But if they do decide to leave their physician was notified and an [redacted] form was filled out and signed. She said the facility did not make anyone in the community aware to ensure they were safe because she said they did not feel the need to notify anyone. She said the residents were educated and it was their choice to leave, and the family was usually aware.

2. Closed record review of R105's "Census" located in the EMR under the "Clinical" tab revealed R105 was admitted on [redacted] with diagnoses that included [redacted].

Review of the "Nurses' Progress Notes," dated [redacted] at 11:52 AM, located under the "Clinical" tab in the EMR revealed R105 "pt [patient] left with [redacted]

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NJ Exec Order 26.4b1 " The progress note was recorded by Licensed Practical Nurse (LPN) 1.

Review of the "NJ Exec Order 26.4b1 " form, provided by the facility and dated NJ Exec Order 26.4 at 11:02 AM, revealed R105 signed the form as NJ Exec Order 26.4b1 person and LPN1 and UM1 signed the form as witnesses. There was no documentation on the form that the physician had been notified.

During an interview on 01/31/24 at 2:40 PM, LPN1 stated she could not remember anything about R105. LPN1 reviewed R105's EMR and stated "hospital, NJ Ex Or didn't go to the hospital, it says NJ Exec Orde LPN1 confirmed it was her signature on the progress note dated NJ Exec Order 26.4b at 11:52 AM. LPN1 stated, "If someone is going NJ Exec Orde we have to fill out a form, get a signature, the U.S. FOIA (b) or the unit manager [(UM) 1] call the doctor, I do not." LPN1 stated she did not know if the physician had been notified, "there isn't anything documented."

During an interview on 02/01/24 at 8:46 AM, UM1 stated she had "no recollection of [R105]" and "no knowledge of who would have called the MD [physician] or if it was done."

During a telephone interview on 02/01/24 at 10:51 AM, R105's Physician (Physician 1) stated, "I know I have not seen this patient. I don't know that I received a text that NJ Ex O went NJ Exec Orde but the facility has to document, this is very important." Physician 1 stated she conducts "rounding" on Tuesdays and Wednesdays. "This resident must have left before I saw NJ Ex Or." "You know they send

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F 660	Continued From page 28 me information to review medications and give orders. I want to see new patients within 48 hours, but I did not see [NJ Ex O] I was not notified [NJ Ex Or] left [NJ Exec Orde] During an interview on 02/01/24 at 1:26 PM, with UM1 and the [U.S. FOIA (D] the [U.S. FOIA] stated, "we try to encourage the resident to stay, if they choose to go [NJ Exec Or] then we inform the physician." The UM1 stated, in the interview on 02/01/24 at 1:26 PM, "the staff should have the resident sign the form and staff, either me or the [U.S. FOIA] call the physician." Review of the facility's policy titled "Discharge Against Medical Advice (AMA)" dated 11/05/23 revealed, the resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. Under no circumstances will the facility force, pressure, or intimidate a resident into leaving AMA. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present. Notify Adult Protection Services, or other entity, as appropriate if self-neglect is suspected. Document accordingly. NJAC 8:39-35.2(d)15,16	F 660		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		2/28/24

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F 684	Continued From page 29 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to accurately screen residents for elopement risk and have measures in place to ensure residents with a wander guard had documented exit seeking behaviors prior to use for one of one resident (Resident (R)76) reviewed for wander guards. Findings include: Review of R76's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed [NJ Ex C] was admitted to the facility on [NJ Exec Order 26.4b] with diagnoses including [NJ Exec Order 26.] [redacted]. Review of R76's quarterly "Minimum Data Set (MDS)" assessment, located under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4b1] revealed [NJ Ex Or] scored [NJ E] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating NJ Exec Order 26.4b1. Further review revealed NJ Exec Order 26.4b1 exhibited. Review of R76's care plan, located under the	F 684	F684 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE IDT met to review R76 behavior [NJ Exec Ord] [redacted] Resident is NJ Exec Order 26.4b1; [NJ Exec Order 26.4b1] was discontinued. NJ Exec Order 26.4b1 to R76 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	

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F 684	Continued From page 30 "Care Plan" tab of the EMR and dated [NJ Exec Order 26.4b], revealed "The resident was care planned for risk for [NJ Exec Order 26.4b1] related to NJ Exec Order 26.4b1 Interventions in place were to distract resident from [NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1. Review of R76's "[NJ Exec Order 26.4b1] Risk Assessment" located under the "Observations" tab in the EMR and dated [NJ Exec Order 26.4b] revealed R76 was [NJ Exec Order 26.4b1]. Review of R76's "physician orders" located under the "Orders" tab in the EMR and dated [NJ Exec Order 26.4] revealed "check [NJ Exec Order 26.4b1] and placement." Review of R76s "Treatment Administration Record" located under the "Orders" tab dated [NJ Exec Order 26.4b1] revealed "Nurse to check placement and function every day and evening shift. Further review revealed no expectation to document [NJ Exec Order 26.4b1] or NJ Exec Order 26.4b1. An observation and interview on 01/30/24 at 12:28 PM of R76 revealed lying in bed on top of linens fully dressed along wearing shoes and NJ Exec Order 26.4b1. R76 said the [NJ Exec Order 26.4b] and [NJ Ex] did not know why [NJ Ex] had to wear it. [NJ Ex] said [NJ Ex] has had it on for about [NJ Exec Order], but staff have never explained to [NJ Ex] why [NJ Ex] needs to wear it. An observation on 01/31/24 at 8:35 AM R76 walked in hallway from resident room to the TV room. R76 went straight to TV room and did not [NJ Exec Order 26.4] or NJ Exec Order 26.4b1 or in the hallway. During an interview on 01/31/24 at 9:31 AM, Certified Nurse Aide (CNA) 1 stated R76 was very	F 684	DON/designee reeducated all licensed nursing staff on identifying residents who meet the criteria for wander guard placement and re-evaluation. All residents who currently have wander guards were reviewed by IDT for appropriateness and use of device. 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 monitor Wander Guard audit weekly X 4 weeks then monthly X 3 months and document findings on audit tool. DON/designee will collect data and report to monthly QAPI for 3 months or longer, until Center has established compliance.	

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NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 of daily living (ADL) care. CNA1 stated R76 was NJ Exec Order 26.4b1 and staff did watch NJ Ex O to NJ Exec Order 26.4b1 CNA1 stated R76 was NJ Exec Order 26.4b1 and NJ Exec Orde in the facility and NJ Exec Order 26.4b1. R76 did not require any NJ Exec Order 26.4b1 for NJ Ex O NJ Exec Order 26.4b1 around the facility and has never been NJ Exec or NJ Exec Order 26.4b1. CNA1 knew R76 wore a NJ Exec Order 26.4b1, but she was unsure why. CNA1 stated R76 did not ever NJ Exec Order 26 around the facility or NJ Exec Order 26.4b1 or in other resident rooms.

During an interview on 01/31/24 at 9:36 AM, Licensed Practical Nurse (LPN) 3 stated R76 was NJ Exec Order 26.4b1 with cares since NJ Ex was very NJ Exec Order 26.4b1 LPN3 stated sometimes R76 would go to the shower room on NJ Ex O own, but staff were supposed to assist NJ Ex Or; R76 spent most of the day sitting in the tv room. LPN3 said NJ Ex would go back and forth between the tv room and NJ Ex O room throughout the day, but that R76 had never NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1. LPN3 stated when R76 NJ Exec Order 2 around NJ Ex knew exactly where NJ Ex was going, and NJ Ex went straight there. LPN3 was unsure why R76 wore a NJ Exec Order 26 . LPN3 said residents who had to wear NJ Exec Order 26.4b1 were NJ Exec Order 26.4b1, but R76 was NJ Exec Order 26.4b1.

During an interview on 02/01/24 at 9:13 AM, Unit Manager (UM) 1 stated residents that were NJ Exec Order 26.4b1 the facility or NJ Exec Order 26.4b1 would need to wear a NJ Exec Order 26 ; or if they were NJ Exec Order 26.4b1 around the facility. UM1 said an NJ Exec Order 26.4b1 risk assessment was completed for all residents on admission, quarterly or as needed.

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UM1 stated a score of [redacted] would mean there was NJ Exec Order 26.4b1 and there would be no need for a NJ Exec Order 26.4b1. UM1 said R76 was observed NJ Exec Order 26.4b1 in the facility over NJ Exec Order 26.4b1 and that when R76 was readmitted from the hospital they discussed the continued need for the NJ Exec Order 26 but did not discontinue it. UM1 stated R76 was NJ Exec Order 26.4b1 but NJ Ex would NJ Exec Order 26.4b1 of the facility, but they were areas NJ Ex was allowed to go. UM1 said there has been ongoing discussion about the continued need for the NJ Exec Order 26.4b1 but there was no documentation for that. UM1 stated staff do not think NJ Exec Order 26.4b1 but that they would rather have a NJ Exec Order 26.4b1 on a resident that does not need it than to miss putting one on a resident that did need it.

During an interview on 02/01/24 at 1:27 PM, the U.S. FOIA (b) (6)) said all residents that were NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 would have a NJ Exec Order 26.4b1 placed on them. The U.S. FOIA stated the NJ Exec Order 26.4b1 was checked on all shifts to ensure they were functioning properly, and staff completed an NJ Exec Order 26.4b1 evaluation quarterly to reevaluate. The U.S. FOIA stated R76 had a NJ Exec Order 26 due to a possible history of NJ Exec Order 26.4b1, But NJ Ex was NJ Exec Order 26.4b1. When asked why the NJ Exec Order 26.4b1 was removed yesterday after it was brought to staff's attention, she said they just met as a team and decided NJ Ex did not need it. But she was unable to state what changed in NJ Ex C behavior or condition day that led to them discontinue the use of a NJ Exec Order 26.4b1.

A review of the facility's policy titled "Elopement/Missing Residents policy and procedure" updated December 31, 2023, revealed, It is always the policy of the facility to

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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
F 684	Continued From page 33 protect residents by identifying and preventing the possibility of elopement and locating residents who are reported missing. Residents who are determined to be an immediate risk for elopement will be placed on wander guard monitoring system when applicable. NJAC 8:39-27.1	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and medical record review, the facility staff failed to obtain a physician order when change in treatment occurred and failed to obtain a physician order for [NJ Exec Order] care when a resident was admitted to the facility for two of five residents (Resident (R) 45 and R32) reviewed for [NJ Exec Order 26.4b1]. Findings included:	F 686	F686 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE 1)R45 obtained MD order.	2/28/24

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 02/01/2024

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 686	Continued From page 34 1. Review of the undated "Admission Record" under the "Profile" tab in the electronic medical record (EMR) revealed R45 was admitted to the facility on [NJ Exec Order 26.4] with the diagnoses including NJ Exec Order 26.4b1 Review of R45's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26.4] coded the resident of having a "Brief Interview for Mental Status (BIMS)" score of [NJ Exec Or] out of a score of 15. This represents R45 was NJ Exec Order 26.4b1 . Review of R45's "Physician Orders," under the "Orders" tab located in the EMR, revealed the order, "NJ Exec Order 26.4b1 every day shift every Mon [Monday], Thu [Thursday] for [NJ Exec Order 26.4b1] started on [NJ Exec Order 26.4] and discontinued on [NJ Exec Order 26.4b]. There were no orders dated for [NJ Exec Order 26.4b1], at which time the facility was NJ Exec Order 26.4b1 which had not been ordered. During an interview on 02/01/24 at 9:19 AM, Unit Manager (UM) 2 stated, R45 admitted to the facility with a [NJ Exec Order 26.4b1] on the [NJ Exec Order 26.4] with a [NJ Exec Order 26.4b1]. UM2 stated, they had problems with the [NJ Exec Order 26.4b1] and stopped using it and started to [NJ Exec Order 26.4b1] with [NJ Exec Order 26.4] and [NJ Exec Order 26.4] it. UM2 stated, "when [ ] went back to the [NJ Exec Order] care clinic, we asked if the [NJ Exec Order 26.4] could be [NJ Exec Order 26.4] because we were having to put our [NJ Exec Order 26.4b1] on it. That visit was a week ago [referring to the last [NJ Exec Order] care visit on [NJ Exec Order 26.4]]." UM2 confirmed there was no notification to the doctor and no orders for [NJ Exec Order 26.4b1] prior to the [NJ Exec Order] care visit on [NJ Exec Order 26.4b].	F 686	2)R32 obtained MD order. NJ Exec Order 26.4b1 to R45 or R32 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 NPE/designee reeducated all nursing staff on Treatment and Services to Prevent Pressure Ulcer, Wound Care Protocols, Wound Documentation. Reviewed all residents with wounds for MD orders. 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 monitor wound care documentation weekly X 4 weeks then monthly X 3 months and document findings on audit tool. DON/designee will collect data and report	

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 02/01/2024

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 686	Continued From page 35 On 02/02/24 at 2:10 PM, the U.S. FOIA (b) (6) was interviewed. The U.S. FOIA (b) (6) stated, ". . . definitely need an order and notification of the doctor for a change in treatment." 2. Review of the undated "Admission Record" under the "Profile" tab in the electronic medical record (EMR) revealed R32 was admitted to the facility on NJ Exec Order 26.4b with the diagnosis of NJ Exec Order 26.4b1 . Review of R32's NJ Exec Order 26.4b "Admission Assessment" under the "Evaluation" tab located in the EMR, revealed R32 was NJ Exec O and NJ Exec Order 26 and was admitted with a NJ Exec Order 26.4b1 present. The admission "Minimum Data Set (MDS)" was not completed at that time of the survey. Review of R32's EMR, since admission on NJ Exec Order 26.4b, revealed there was no documentation or orders for NJ Exec Order care until NJ Exec Order 26.4b During an interview on 01/31/24 at 2:23 PM, UM2 stated, "The nurse that admitted [R32] should go by the orders that come with the resident or we use NJ Exec Order 26.4b1 on it until the NJ Exec Order care team sees them. The nurse that admitted NJ Ex O was here I think all weekend and she would have been performing the NJ Exec Order 26.4b1. There is a protocol, but I don't know if all the nurses use it." During an interview on 01/31/24 at 3:10 PM, the U.S. FOIA (b) (6)) stated, "The nurse will assess the NJ Exec Order 2 we have standing orders for treatment, and confer with the doctor to see if he	F 686	to monthly QAPI for 3 months or longer, until Center has established compliance.	

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 02/01/2024

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 686	Continued From page 36 wants these orders. This should be done on admission for any resident that is found to have a [NJ Exec Order 26] During an interview on 01/31/24 at 3:10 PM, Licensed Practical Nurse (LPN) 4 stated, "I used [NJ Exec Order 26.4b] on it and NJ Exec Order 26.4b1 We sprayed [NJ Exec Order 26.4b] on it each day and [NJ Exec Order 26] it with a [NJ Exec] and placed a [NJ Exec] on it ...I didn't have a chance to document. I totally forgot; it was so busy with admissions." LPN4 stated the [NJ Exec Order] treatment was a nursing judgement, she did not recall if she notified the physician of the [NJ Exec Order] treatment. NJAC 8:39-27.1(e)	F 686		

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 02/01/2024

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) 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 (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 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	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 what systematic changes will be made to	2/28/24

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

Electronically Signed | 02/22/24

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 02/01/2024

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) COMPLETE DATE
S 560	Continued From page 1 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 06/18/2023 to 06/24/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -06/18/23 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -06/24/23 had 12 CNAs for 111 residents on the day shift, required at least 14 CNAs. 2. For the 2 weeks of staffing prior to survey from 01/14/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -01/14/24 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -01/21/24 had 9 CNAs for 112 residents on the day shift, required at least 14 CNAs. -01/23/24 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -01/25/24 had 12 CNAs for 112 residents on the day shift, required at least 14 CNAs.	S 560	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. • 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.	

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 02/01/2024

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 560	Continued From page 2 -01/26/24 had 13 CNAs for 112 residents on the day shift, required at least 14 CNAs. -01/27/24 had 10 CNAs for 112 residents on the day shift, required at least 14 CNAs.	S 560		

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
315273 Y1	A. Building B. Wing Y2	4/21/2024 Y3

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 F0550	Correction	ID Prefix F0640	Correction	ID Prefix F0655	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(a)(1)-(3)	Completed
LSC	02/22/2024	LSC	02/28/2024	LSC	02/28/2024
ID Prefix F0658	Correction	ID Prefix F0660	Correction	ID Prefix F0684	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.21(c)(1)(i)-(ix)	Completed	Reg. # 483.25	Completed
LSC	02/28/2024	LSC	02/28/2024	LSC	02/28/2024
ID Prefix F0686	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(b)(1)(i)(ii)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/28/2024	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?
2/1/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
062022	A. Building B. Wing	4/21/2024

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 02/28/2024	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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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

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 2/1/2024	☐ 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		4/21/2024

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 02/28/2024	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
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

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	
2/1/2024	☐ 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
	315273	A. BUILDING **01** B. WING _____	**02/01/2024**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, (NJDOH) on 01/31/24. 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 the Health Care Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/31/24 and was found not to be in compliance with 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 Woodlands is a two-story building first occupied in 1989 according to staff. The facility is constructed of type III (200) construction with concrete flooring with steel joists and I-beams on the first floor, stucco exterior, and wood frame protected roofing. The facility has a 400-kilowatt (KW) diesel generator. The ground floor has residential and service areas. The facility does not know the percentage of load carried by the generator. The facility has six smoke zones and had 115 occupied beds.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by	K 161		5/1/24

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

Electronically Signed | 02/21/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315273	A. BUILDING **01** B. WING _____	**02/01/2024**

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
K 161	Continued From page 1 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the building structure met height	K 161	Ceiling tiles K161 SS-F	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315273	A. BUILDING **01** B. WING _____	**02/01/2024**

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
K 161	Continued From page 2 and construction requirements in accordance with NFPA 101 (2012 edition) table 19.1.6.1. This deficient practice had the potential to affect all 115 residents. Findings include: An observation on 01/31/24 at 1:00 PM of the building structure revealed a two-story facility with stucco exterior for both floors, wood frame roofing protected by two layers of 5/8 inch dry wall for one hour protection and a concrete floor between the Oak unit and Maple unit supported by metal unprotected I-beams and metal framing. The areas were covered in ceiling tile that offered no fire resistance rating leaving the metal supports unprotected. Further observation of the back of the ceiling tiles and replacement package did not show a rating of one hour or fire resistance of one hour. During an interview at the time of the observation, the U.S. FOIA (b) (6) indicated he had been employed at the facility for a long time. The U.S. FOIA (b) (6) also stated the ceiling tiles had not been changed or updated and he was not aware if the ceiling tiles were rated. NJAC 8:39-31.2(e)	K 161	How the corrective action/actions will be accomplished for those residents found to be by the practice The facility failed to ensure the building structure met height and construction requirements. Ceiling that are properly fire rated to code will be installed to replace identified deficient tiles. How the facility will identify other residents having the potential to be affected by the deficient practice Deficient practice has the potential to affect all residents. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur? Center Maintenance / designee has received education regarding proper safety compliant rated ceiling tile usage to be in compliance with code construction requirements. 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 Maintenance Director or Designee will conduct safety audit quarterly and review results to ensure proper safety rated tiles are utilized at Quarterly QAPI for one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315273	A. BUILDING **01** B. WING _____	**02/01/2024**

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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K 161	Continued From page 3	K 161	Completion Date 05-01-2024	
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, 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 one exit was maintained free of obstructions and impediments for full and instant use in accordance with NFPA 101 (2012 edition) section 7.1.10.1. for one of 15 exits. This deficient practice had the potential to affect 12 residents on the Glen unit. Findings include: An observation on 01/31/24 at 11:10 AM of the exit door leading to the exit discharge in Stairway A, in the service area below the Glen unit revealed the door would not readily open. Several attempts were made before the door could be opened. After the door was opened, the problem was diagnosed as a raised threshold. During an interview at the time of the observation, the U.S. FOIA (b) (6) indicated salt to melt the snow had gathered under the threshold causing it to rise and prevent the door from	K 211	Means of Egress K211 How the corrective action/actions will be accomplished for those residents found to be by the practice Means Egress Facility failed to ensure one exit was maintained free of obstructions and impediments for full and instant use. Identified deficient door was corrected immediately by removing the obstruction inhibiting door egress. How the facility will identify other residents having the potential to be affected by the deficient practice This deficit practice had the potential to affect 12 residents on the Glen Unit. What measures will be put in place or what systematic changes will be made to	3/15/24

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	315273	A. BUILDING **01** B. WING _____	**02/01/2024**

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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K 211	Continued From page 4 opening. NJAC 8:39-31.1(c), 31.2(e)	K 211	ensure that the deficient practice will not recur? Maintenance Department staff and Center staff received education regarding maintaining all Center egresses free of obstruction and impediments to ensure full and instant use. The Center Maintenance Director/Designee will monitor egresses with weekly egress audits to ensure exit doors are free of obstructions and impediments for instant usage. 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 Center Maintenance Director/Designee will collect data and report to monthly QAPI for three months or longer , until Center has established compliance. Completion Date 03-15-2024	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure illumination was available at the	K 281	Illumination of Means of Egress K281	3/15/24

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K 281	Continued From page 5 exit discharge from the Physical Therapy room in accordance with NFPA 101 (2012 edition) section 7.8.1.1. This deficient practice had the potential to affect four residents and four staff that were present in the room at the time of the observation. Findings include: An observation on 01/31/24 at 11:45 AM of the exit discharge at the Physical Therapy room revealed there was no emergency lighting connected to the generator. There were no lighting outlets anywhere at this exit discharge. During an interview at the time of the observation, the U.S. FOIA (b) (6) verified the lack of emergency lighting that was connected to the emergency generator. NJAC 8:39-31.2(e)	K 281	How the corrective action/actions will be accomplished for those residents found to be by the practice The facility failed to ensure illumination was available at the exit discharge from the Physical Therapy room in accordance with. NFPA 101. Illumination will be installed. How the facility will identify other residents having the potential to be affected by the deficient practice Potential to affect all residents seeking exit through the identified exit. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur? The Maintenance Director received education regarding proper means of egress illumination regarding all Center egress points. 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 Maintenance Director/ Designee will conduct safety rounds to review proper illumination of egress monthly for three months then annually at Center Safety audit. Center Maintenance Director or Designee will collect date and report monthly at QAPI for three months or longer until compliance is established.	

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K 281	Continued From page 6	K 281	Completion Date March 15, 2024	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure three hazardous area room doors	K 321	Hazardous Room Doors K 321 SS=E	3/15/24

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K 321	Continued From page 7 were in accordance with NFPA 101 (2012 edition) section 19.3.2.1. This deficient practice had the potential to affect 74 residents. Findings include: An observation on 01/31/24 at 10:40 AM of the soiled linen room door in the main exit access corridor near bedroom 118 revealed a large crack in the door measuring 24 inches long. The area was filled with sections of wood filer that had fallen away leaving holes and cracks. The room contained three soiled linen containers holding 33 gallons each of soiled linens. The containers were all half full. During an interview at the time of the observation, the U.S. FOIA (b) (6) verified the condition of the door and stated he had tried to fix the door, but it did not work. An observation on 01/31/24 at 11:00 AM of the soiled linen room door in the corridor of the service hallway revealed a large section of paper towel stuffed in the bore hole of the door frame preventing the door from closing. The room contained four 100-gallon containers of soiled linen, with one being completely full. During an interview at the time of the observation, the U.S. FOIA (b) (6) verified the finding and removed the paper from the bore hole. During an observation on 01/31/24 at 11:35 AM of a room behind the reception desk that was in the main corridor and led to the administrator's office, with a door on each end revealed the room contained five, 6 foot (ft) tall filing cabinets full of paper including six reams of printer paper. The	K 321	How the corrective action/actions will be accomplished for those residents found to be by the practice Hazardous Areas Enclosure The facility failed to ensure three hazardous room doors were compliant. Center has replaced identified deficient Door. (Near room 118) picture included. Two identified deficient doors without self-closing devices were correct by adding self-closing devices. Deficient door closure with identified obstruction paper towel was removed immediately. How the facility will identify other residents having the potential to be affected by the deficient practice All residents have the potential to be affected by the same deficient practice. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur? Center staff received educating regarding proper hazardous area enclosures and to inhibit doors from closing. Maintenance and designee received education regarding proper door closure maintenance. Center Maintenance Director/ Designee will conduct door audit rounds monthly for three months to ensure all doors are in accordance with safety Code. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What Quality	

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K 321	Continued From page 8 door to the reception area and door to the administrator's office had self-closing devices that had both been removed. During an interview at the time of the observation, the U.S. FOIA (b) (6) stated he did not know how long the two door closers had been removed. The U.S. FOIA (b) (6) also stated the doors were preventing easy access to the area by the reception office and from his office. NJAC 8:39-31.2(e)	K 321	Assurance will be put in place. Maintenance Director Designee audit results will be reviewed at monthly QAPI and quarterly meeting to ensure code compliance. See the door pictured in attachment. This photo is the door replacement Identified near room (118), Completion Date 03-15-2024	
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure two of 154 photo electric smoke detectors were greater than	K 341	Fire Alarm System Installation K341 SS=E	3/1/24

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K 341	Continued From page 9 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 29.8.3.4.(6). This deficient practice had the potential to affect 34 residents in two smoke zones. Findings include: An observation on 01/31/24 at 10:40 AM of a smoke detector in the corridor soiled linen room near bedroom 118 revealed the smoke detector was 14 inches from a heating and cooling air diffuser as measured by the U.S. FOIA (b) (6) [redacted] An observation 01/31/24 at 11:15 AM of a smoke detector in the corridor near the electric room in service area 305 revealed the smoke detector was 20 inches from a heating and cooling air diffuser as measured by the U.S. FOIA (b) (6) [redacted] A review of the "Fire Alarm Cleaning and Sensitivity Report" and the "Inspection Worksheet," dated 08/17/21, 01/18/23, and 10/19/23 revealed no mention or record of the two noted smoke detectors too close to air diffusers. During interviews at the time of both observations, the U.S. FOIA (b) (6) verified the distance and stated he was not aware of the requirement. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 341	How the corrective action/actions will be accomplished for those residents found to be by the practice Facility failed to ensure two of the photo electric smoke detectors were greater than 36 inches from the ceiling air diffusers. Smoke detectors were relocated greater than 36 inches from the ceiling air diffusers to meet established code standards. How the facility will identify other residents having the potential to be affected by the deficient practice All residents have the potential to be affected by the deficient practice. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur? Education provided maintenance regarding acceptable distance for air diffusers and smoke detectors. Maintenance Director /Designee will conduct fire safety audit quarterly for one year to ensure smoke locations detectors are in compliance. 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 center Maintenance Director or Designee will review results quarterly to ensure proper compliance in quarterly QAPI meeting.	

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K 341	Continued From page 10	K 341	Completion Date 03-01-2024	
K 522 SS=E	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure a natural gas fueled fireplace located in the main dining room was installed and used in accordance with NFPA 101 (2012 edition) section 19.5.2.2. This deficient practice has the potential to affect 40 residents in the smoke zone. Findings include: Observation on 01/31/24 at 11:45 AM of a large two-sided natural gas fueled fireplace in the main dining room on the second floor revealed the unit lacked a condition to provide air from the outside for combustion. Continued observation revealed the fireplace lacked a complete separation of the fireplace from the occupied area such as sealed glass doors; and lacked a stop flow switch to shut	K 522	Gas fueled fireplace K522 SS=E How the corrective action/actions will be accomplished for those residents found to be by the practice The facility failed to ensure a natural gas fueled fireplace located in the main dining room was installed and used in accordance too code. The heating device gas supply has been permanently capped rending the device nonfunctional. Eliminating safety hazard. How the facility will identify other residents having the potential to be affected by the deficient practice The deficient practice has the ability to	3/1/24

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K 522	Continued From page 11 off the fuel supply when the device did not ignite or became too hot. During an interview at the time of the observation, the U.S. FOIA (b) (6) stated he had been at the building since it opened. He stated the fireplace had only been used a small number of times. The U.S. FOIA (b) (6) also stated the facility did not have documentation regarding the fireplace and its components to determine compliance with the items noted above. NJAC 8:39-31.2(e)	K 522	affect 40 residents in the smoke zone. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur? " The heating device was disengaged rendering it inoperable to eliminate safety hazard. Cap installed is permanent and secure. " Maintenance Director /Designee will conduct annual safety rounds to ensure capped gas is secure and remains in compliance. " Education provided to Maintenace regarding Heating Device maintenance, usage, and safety management. 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 Center Maintenance Director/ Designee will conduct safety audit monthly for three months and document results on audit tool. Cap will be reviewed annually during Center safety audit to assure capped remains secure and in compliance. " Maintenance Director/ Designee will collect data and report monthly at QAPI for three months to ensure it is inoperable and remains in compliance. Annually during annual safety Audit.	

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{E 000}	Initial Comments The facility was found to be in compliance with 42 CFR 483.73.	{E 000}		
{K 000}	INITIAL COMMENTS An off-site/desk review of the Life Safety Code Plan of Correction was 05/06/24 and the facility was found not to be in compliance with 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, specifically K161. Complete Care at Woodlands is a two-story building first occupied in 1989 according to staff. The facility is constructed of type III (200) construction with concrete flooring with steel joists and I-beams on the first floor, stucco exterior, and wood frame protected roofing. The facility has a 400-kilowatt (KW) diesel generator. The ground floor has residential and service areas. The facility does not know the percentage of load carried by the generator. The facility has six smoke zones and was certified for 120 beds.	{K 000}		
{K 161} SS=F	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of	{K 161}		5/6/24

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

Electronically Signed | 05/07/2024

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{K 161}	Continued From page 1 stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on off-site/desk review conducted on 05/06/2024, the facility failed to submit an acceptable Plan of Correction including evidence that the building structure met height and construction requirements in accordance with NFPA 101 (2012 edition) table 19.1.6.1. This deficient practice had the potential to affect all	{K 161}	Ceiling tiles K161 SS-F How the corrective action/actions will be accomplished for those residents found to be by the practice The facility failed to ensure the building	

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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
{K 161}	Continued From page 2 residents. Findings include: During the 02/01/2024 Recertification survey the building structure revealed a two-story facility with stucco exterior for both floors, wood frame roofing protected by two layers of 5/8 inch dry wall for one hour protection and a concrete floor between the Oak unit and Maple unit supported by metal unprotected I-beams and metal framing. The areas were covered in ceiling tile that offered no fire resistance rating leaving the metal supports unprotected. Further observation of the back of the ceiling tiles and replacement package did not show a rating of one hour or fire resistance of one hour. NJAC 8:39-31.2(e)	{K 161}	structure met height and construction requirements. Ceiling that are properly fire rated to code will be installed to replace identified deficient tiles. How the facility will identify other residents having the potential to be affected by the deficient practice Deficient practice has the potential to affect all residents. What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur? Center Maintenance / designee has received education regarding proper safety compliant rated ceiling tile usage to be in compliance with code construction requirements. 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 Maintenance Director or Designee will conduct safety audit quarterly and review results to ensure proper safety rated tiles are utilized at Quarterly QAPI for one year.	

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
315273 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/6/2024 Y3

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		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0211	03/15/2024	LSC	K0281	03/15/2024	LSC	K0321	03/15/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0341	03/01/2024	LSC	K0522	03/01/2024	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	
2/1/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315273 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	5/31/2024 (Y3)

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

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0161	Correction Completed 05/06/2024	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
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

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	
2/1/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO