

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

PRINTED: 07/31/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>315273</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/20/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>COMPLETE CARE AT WOODLANDS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1400 WOODLAND AVE PLAINFIELD, NJ 07060</b>		
(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	<p>INITIAL COMMENTS</p> <p>Complaint #: NJ00174376, NJ00174932, NJ00181413, NJ00182680, NJ00182975, NJ00183400</p> <p>Survey Dates: 03/28/2024, 04/01/2024 &amp; 04/04/2024</p> <p>Census: 106</p> <p>Sample Size: 08</p> <p>THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/06/2025

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

New Jersey Department of Health

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S 560	<p>8:39-5.1(a) Mandatory Access to Care</p> <p>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 1 of 14 day shifts. The deficient practice was evidenced by the following:</p> <p>Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021:</p> <p>One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff</p>	S 560	<p>Mandatory Access to Care S 560 Staffing</p> <p>How the corrective action/actions will be accomplished for those residents found to be by the practice Inadequate number of Certified Nursing Assistants</p> <p>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.</p> <p>What measures will be put in place or what systematic changes will be made to ensure that the deficient practice will not recur? " 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</p>	6/9/25

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S 560	<p>Continued From page 1</p> <p>member shall sign in to work as a CNA and perform CNA duties."</p> <p>For the 3 weeks of AAS-11 staffing, the facility was deficient as follows:</p> <p>-For the 2 weeks of Complaint staffing from 05/04/2025 to 05/17/2025, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows:</p> <p>-05/11/25 had 12 CNAs for 104 residents on the day shift, required at least 13 CNAs.</p>	S 560	<p>coverage.</p> <p>" The staffing agency will block a schedule for the open position to cover the vacancies.</p> <p>How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What Quality Assurance will be put in place</p> <p>" The Staffing Coordinator will audit the staffing weekly for 4 weeks then monthly for 2 months.</p> <p>The Staffing Coordinator will submit the audit report to the Quality Assurance Improvement Committee which meets quarterly.</p> <p>Completion Date 06-09-2025</p>	

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 062022 <span style="float:right">Y1</span>	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 6/18/2025 <span style="float:right">Y3</span>
NAME OF FACILITY COMPLETE CARE AT WOODLANDS	STREET ADDRESS, CITY, STATE, ZIP CODE 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/09/2025	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	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 5/20/2025		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		