STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315050	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Burlington Woods, LLC	115 Sunset Road Burlington, NJ 08016

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Complaint #2698562Based on interviews, record review of the medical records, and other pertinent facility documents on 1/27/26, it was determined that the facility failed to provide adequate assessment and to provide needed care or services to manage resident's symptoms in accordance with professional standards of practice; after they received report from the resident's family member that the resident had decline in condition. This deficient practice was identified for 1 of 4 residents, (Resident #2) reviewed and was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.According to the admission Record, Resident #2 was admitted to the facility with diagnoses which included but not limited to: Sepsis (a potentially life-threatening condition that arises when the body's dysregulated response to infection causes injury to its own tissues and organs), Chronic Obstructive Pulmonary Disease (a group of lung diseases that cause progressive airflow obstruction and breathing difficulties), Type 2 Diabetes Mellitus (high blood sugar), and Diastolic Congestive Heart Failure (a stiff left heart ventricle).The Minimum Data Set (MDS), an assessment on 10/24/2025, indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the Resident's cognition was intact. According to statement written by the Licensed Practical Nurse (LPN #1) indicated, that at approximately at 7:30pm, the resident's family who was visiting with the resident, came to the nursing station and told LPN #1 that the resident looked septic. According to the progress note (PN) written by LPN #1, dated 10/28/25 at 2220 (10:20PM), LPN #1 notified the Nursing Supervisor of the family's report and the supervisor assessed the resident, and obtained vitals as follows: Blood Pressure 142/101, Heart Rate 126, Pulse Oximetry 97 and Blood sugar of 438, Temperature 98.1 and Respiratory Rate of 17. The PN stated that the Medical Doctor was notified. LPN #1 documented in the PN that the resident's family insisted to send the resident to the hospital. The PN stated that 911 was called, all resident information was given to them, resident was taken to the Hospital.On 1/27/26, the Surveyor reviewed Resident #2's Progress Note (PN), and there was no documentation in Resident #2's medical record regarding the Registered Nursing Supervisor's (RNS) assessment findings and how she addressed the resident's elevated blood sugar. There was no documentation regarding the time a physician was notified and what the physician ordered for her to do about the high blood sugar of 438.On 1/27/2026, the surveyor reviewed a document titled: Weights and Vital Summary (a report of vital signs taken) with an effective date range of 10/1/2025 - 1/31/2026 which revealed the following:A review of Resident #2's Weights and Vital Summary under Blood Sugar Summary revealed that on 10/28/25 at 19:54, the resident's blood sugar was 438 mg/dL. The surveyor noted that the (continued on next page)

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.

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation.Under Policy Explanation and Compliance Guidelines:1. Licensed staff . shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.4. Principles of documentation include .a. Documentation shall be factual, objective, and resident centered.i. False information shall not be documented.ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. NJAC 8:39-27.1(a)