STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. Building B. Wing	09/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Orange Park	140 Park Ave East Orange, NJ 07017

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 09/18/2025 from 9:37 AM until 10:06 AM, the surveyor observed the following in the kitchen in the presence of the Dietary Director (DD): 1.The Food Service Worker (FSW#1) had facial hair and was not wearing beard guard. The DD#1 stated the FSW#1 should have a beard guard. 2. In the walk-in refrigerator, a prepared salad had a label which reflected prep 9/15 expire 9/17. The DD stated it was out of date and threw the salad out.3. In the walk-in refrigerator, a plastic bag of fresh basil dated 9/10 with soft brown areas on several leaves. The DD stated the basil looks a little soft gonna toss it. 4. The Food Service Worker (FSW#2) had facial hair and was not wearing beard guard. The DD stated the FSW#2 should have a beard guard. A review of facility provided policy titled, [NAME] Guard Policy, with a revision date of 6.2024 reflected: all dietary staff with facial hair that is not clean-shaven are required to wear an appropriate beard guard while working in food preparation, service, or storage areas. A review of the facility provided policy titled, Labeling and Dating System Protocol/Policy, revised 7/2025 reflected: all fresh and frozen foods must be dated with the date it was received in the kitchen unless it has a purveyor shipping label on it, all food items must be properly labeled, dated, and always covered, and produce facility cut up and prepped exception tomato and lettuce 3 days.A review of the facility provided policy titled, Dating and Storage of Fresh Herbs, with a revision date reflected: discard herbs that are slimy, moldy. NJAC 8:39-17.2(g)

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 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Complaint #425693Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure that residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. The deficient practice was identified for 1 of 2 (Resident # 167) residents reviewed for Physician Visits. The deficient practice was evidenced by the following: A review of Resident # 167's Electronic Medical Record (EMR) revealed he/she was admitted in March of 2025.A review of Resident # 167's EMR revealed he/she was diagnosed with but not limited to unspecified sequelae of cerebral infarction (long term conditions of a stroke) and type 2 diabetes mellitus without complications (inability to control blood-sugar).A review of the Progress Notes for Resident # 167 revealed a late entry by a Physician that was created on 04/14/2025 and dated for 03/30/2025.A review of Resident # 167's EMR did not reveal any other documented visits from the Physician.A review of the Progress Notes revealed the Resident was seen by the Family Nurse Practitioner on the following dates:3/31/20254/01/20254/3/20254/7/20254/8/20254/10/20254/11/20254/15/20254/17/20254/18/20255/5/202 09/23/2025 at 10:59 AM during an interview with the Surveyor, the Regional Clinical Director said that the requirement for physician visits in the facility occur at thirty, sixty, ninety, and one-hundred and twenty days. She concluded that after the ninetieth day, the Nurse Practitioner can share with the Physician.On 09/24/2025 at 10:25 AM during an interview with the Surveyor, the Regional Clinical Director confirmed that prior to May of 2025, the attending Physician for Resident # 167 was identified by the facility as being noncompliant with physician visits. She said further that a new Medical Director was installed in May, and physician visits have improved. At that time, the Director of Nursing confirmed there is no further documentation that the attending Physician visited Resident # 167 during that time.A review of the facility provided policy titled, Physician Visits and revised in April of 2020 revealed that, 2. The Attending Physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter.S 8:39-23.2 (d)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews from 09/18/2025 to 09/22/2025 in the presence of the Regional Maintenance Director (RMD) and the Maintenance Director (MD), it was determined that the facility failed to ensure that the resident call bell system was properly functioning in all areas. This deficient practice had the potential to affect 3 residents and was evidenced by the following:Observations on 09/19/2025 from 10:14 AM to 11:01 AM revealed the following:The call bell cord was missing from resident room [ROOM NUMBER]. The resident was in bed at the time. The surveyor asked the resident how long the call bell cord has been missing and the resident stated, For a couple of days. Additionally, there was no indication that the call bell cord was missing at the call bell system annunciator panel.Visual notification of the activation of the call bell system was not provided at the call bell annunciator panel when testing the call bell for resident room [ROOM NUMBER]. The indicating bulb was not functioning.The call bell did not activate when tested by the MD for resident room [ROOM NUMBER]-window bed. In interviews at the time, the MD confirmed the observations. The facility's Administrator, RMD and MD were informed of the deficient practice at the Life Safety Code exit conference on 09/22/2025 at 12:00 PM. N.J.A.C 8:39-31.2 (e), 31.8(c)9

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to maintain a clean and sanitary environment for 2 of 3 units, the first floor second floor.This deficient practice was evidenced by the following: During initial tour on 09/18/2025 at 10:02 AM survey #1 observed the following: 1. A hole in the wall behind the door of room [ROOM NUMBER]. 2. In room [ROOM NUMBER] the molding at the bottom of the wall was peeling off and there were two tiles with peeling at the edges. On 09/18/2025 at 10:24 AM during the initial tour of the facility in room [ROOM NUMBER], the Surveyor observed a scissors with soiled adhesive surgical tape attached to it on the windowsill. On the same date at 10:32 AM while in the shower room outside of room [ROOM NUMBER], the Surveyor observed geriatric recliners, a wheelchair, and mechanical lift stored in the shower room. Within the bathroom area of the shower room, the Surveyor observed a broken toilet paper holder and toilet paper placed on top of the toilet tank. On 09/19/2025 at 9:57 AM while in room [ROOM NUMBER], the Surveyor observed the scissors with soiled adhesive surgical tape attached to it on the windowsill. 09/23/2025 at 10:59 AM during an interview with the Surveyor, the Director of Nursing stated, That should not be there after reviewing the Surveyor's finding of the scissors in room [ROOM NUMBER]. During an interview with surveyor #1 the Regional Director of Nursing said there should not be peeling molding and tile, or holes in the walls of resident rooms because it's not a homelike environment A review of a facility provided policy dated 01/04/2025 and titled safe and Homelike environment revealed under, Policy Explanation and Compliance Guideline: that, 3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. N.J.A.C. 8:39-31.4(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to obtain a Physician's Order (PO) for an orthotic device for 1 of 2 residents (Resident#80) reviewed for positioning and mobility. On 09/18/2025 at 11:36 AM, the surveyor observed resident #80 in a wheelchair. An orthotic device was observed on the left leg of Resident #80. According to the admission Record, Resident #80 was admitted to the facility with a diagnosis including but not limited to left foot drop. Review of the Annual Minimum Data Set (MDS), an assessment tool utilized to facilitate the management of care, dated 07/01/2025 reflected that the resident was cognitively intact and had impaired use of the lower extremity on one side of the body. Review of the Order Summary Report with active orders as of 09/21/2025 did not reveal an order for Resident #80's orthotic device for the left leg. Review of Resident #80's current Care Plan did not reflect the use of the orthotic device. During an interview with the surveyor on 09/22/2025 at 11:13 AM, the Unit Manager stated that there should be a physician order for an orthotic. She acknowledged that there was no physician order for Resident #80's orthotic.During an interview with the surveyor on 09/24/2025 at 10:33 AM, the Director of Nursing stated that there should be a physician order for an orthotic. The facility was unable to provide a policy regarding having a physician order for an orthotic. NJAC 8:39-27.1 (a)