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	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Woodlands	1400 Woodland Ave Plainfield, NJ 07060

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48618 Complaint#: NJ00175265 Based on observation, interview, review of medical records and other pertinent facility documentation on 09/24/24 and 09/25/24, it was determined that the failed to maintain an accurate and complete medical record in accordance with acceptable standards and practice by not documenting a registered nurse's (RN) assessment of a resident that presented with a change in condition. The facility also failed to follow it's Charting and Documentation policy. This deficient practice was identified for 1 of 3 residents (Resident #1) reviewed and was evidenced by the following: On 09/24/24, at 11:11 A.M., the surveyor observed the resident seated in a wheelchair beside the bed. The resident stated that staff was sometimes responsive to resident's needs. According to the facility Admission Record, Resident #1 was admitted with diagnoses that included, but were not limited to hemiplegia (paralysis of one side of the body) and hemiparesis (a condition that causes weakness or an inability to move on one side of the body), anxiety, and major depressive disorder. The Quarterly Minimum Data Set (MDS), dated [DATE], an assessment tool used to facilitate the management of care revealed that Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated that the resident's cognition was intact. The surveyor reviewed Resident #1's progress notes which revealed the following: -On 5/24/24, at 10:27 P.M., a Licensed Practical Nurse (LPN) documented, Resident vomitingx1. Stomach soft and nondistended. Bowel sounds noted to all four quadrants . -On 5/26/24, at 6:37 A.M., an LPN documented, Resident was noted to have had x2 loose stools. -On 5/27/24, at 3:47 P.M., an LPN documented, . resident vomiting coffee ground liquid x3 and diarrhea. Stomach soft and nondistended. Bowel sounds noted to all four quadrants . A further review of the resident's progress notes failed to provide documented evidence that the resident was assessed by a registered nurse during any of the aforementioned days. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/24/24, at 3:06 P.M., the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated that any change in a resident's condition should be reported by an LPN to an RN. She further stated that episodes of nausea, vomiting, and loose stools/diarrhea were each considered a change in a resident's condition that should have been reported to the RN on the unit and who then should assess the resident. The RN/UM further stated that she recalled the aforementioned dates and that she did assess the resident during that time period. She further stated that she could not recall why she did not document her assessments, but that she should have. On 09/25/24, at 1:05 P.M., the surveyor interviewed the Director of Nursing (DON) who stated that her expectation is that any change in a resident's condition that is noted by an LPN should be reported to an RN, who should then verify the data and document it. The surveyor reviewed the facility's Charting and Documentation, policy, revised January 2023, revealed that all services provided to the resident were to be documented in the medical record. The Policy Interpretation and Implementation section revealed a list of information was that was to be documented in the medical record including, . d. Changes in the resident's condition . NJAC 8:39-27.1(a)