STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE , CLARK, New Jersey, 07066

(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
F0000	INITIAL COMMENTS Complaint #'s: NJ00179287, NJ00181477, NJ00181857, NJ00183738 Standard Survey: 5/9/25 -5/15/25 Census: 126 Sample Size: 25 + 3 closed records The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F0000		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies	F0607	1. LPN #1 had a background check that was completed on NJ Exec Order 2 [redacted] 2. All Residents have the potential to be affected by the deficient practice. 3. The Human resources director conducted an audit of all current employees to ensure a background check is in place. The facility administrator educated the U.S. FOIA (b) (6) [redacted] regarding new hire/ onboarding policy. 4. The Human resources director or designee will audit all new hire personnel files, monthly for three months to ensure that each new hire has a completed background check in place on the date of hire prior to the start date. The result will be brought to the quarterly Quality Assurance Performance Improvement meeting for further review and recommendations by the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	05/31/2025

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 reverse for further 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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F0607 SS = D	Continued from page 1 and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, employee file review, and review of other pertinent documents, it was determined that the facility failed to implement their abuse policy to ensure a criminal background check was completed for one (1) of ten (10) NJ Exec Order 26.4b1 staff (Licensed Practical Nurse #1) reviewed for criminal background checks. This deficient practice was evidenced by the following: On 5/14/25, the surveyor reviewed ten (10) randomly selected new employee files which revealed the following: - LPN #1 had a date of hire (DOH) of NJ Exec Order 2 Review of the file revealed a physical dated NJ Exec Order, a criminal background check dated NJ Exec Order 2, and reference checks dated NJ Exec Order 26.4b1 On 5/14/25 at 2:10 PM, during a meeting with the survey team, the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6)) confirmed LPN #1 was "onboarded" (hired) by the facility on NJ Exec Order. They stated prior to that date, she worked at the facility but was employed by an NJ Exec Order The U.S. FOIA confirmed that LPN #1 was officially employed by the facility on NJ Exec Order2 On 5/15/25 at 10:31 AM, the surveyor interviewed the U.S. FOIA (b)(6) When asked about the hiring process for new staff, she stated when the interview was done, and the facility was offering the position, she tells the applicant "I am offering you the position based on results of the background check	F0607		

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F0607 SS = D	Continued from page 2 and the reference checks." The [U.S. FOIA] stated the Registered Nurse Assessment (RNA) and the physical would be done once the background check was completed. She stated the RNA would be done on the first day of work and then the Advanced Practical Nurse would complete the physical within 30 days of hire. At that time the [U.S. FOIA] reviewed the employee file for LPN #1 in the presence of the surveyor, she confirmed the DOH o[NJ Exec Order 2[redacted]], the physical dated [NJ Exec Order[redacted]], and the background check dated [NJ Exec Order 2[redacted]]. She stated LPN #1 had worked for an [NJ Exec Order[redacted]] prior to starting with the facility. She stated the facility had done the background check on LPN #1 for the [NJ Exec Order[redacted]] at that time [NJ Exec Order 26.4[redacted]] but could not speak to why a background check was not done upon hire by the facility. She stated, "it looks like a background check should have been ran before she started here." She confirmed the RNA was not in the file. On 5/15/25 at 10:41 AM, the surveyor interviewed the [U.S. FOIA (b)(6)[redacted]]) regarding the hiring process. They all stated the background check would be done upon hire, prior to starting work. The surveyor made them aware of the above concerns for LPN #1's background check and her physical. 05/15/25 11:28 AM, the [U.S. FOIA[redacted]] provided the RNA for LPN #1, dated [NJ Ex Order 26[redacted]]. No additional information was provided. A review of the facility's policy "Abuse, Neglect and Exploitation" revised: 5/1/2025 revealed Policy: It is the Policy of this facility to provide protections for health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. I. Screening: A Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credentials' checks shall be conducted on potential employees ... A review of the undated facility's policy "Background Check Policy and Procedure" revealed all offers of employment at Complete Care are contingent upon clear results of a thorough background check ...Human Resources will order the background check upon receipt	F0607		

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F0607 SS = D	Continued from page 3 of the signed release form, and either internal HR staff or an employment screening service will conduct the checks. NJAC 8:39-9.3(b)	F0607		
F0658 SS = E	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, interviews, record review, and facility documents, it was determined that the facility failed to ensure Licensed Practical Nurse's (LPN) followed the physician's order (PO) in accordance with professional standards of nursing practice for 1 of 6 residents (Resident #58) reviewed for unnecessary medications. 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 registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 case finding; 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."	F0658	1. Resident #58s medication administration orders were immediately reviewed and updated to reflect RN signature is required. LPN#1, LPN#2, LPN#3, LPN#4, and LPN#5 were educated on following the physicians orders and proper documentation of physicians orders on the medication administration record. Resident #58 was assessed and there was not negatively affected from the deficient practice. Facility wide education on the management of [redacted] medication management was conducted by the Assistant Director of Nursing. All Medication administration records for the resident #58 were audited for [redacted] and all discrepancies identified were addressed by the director of nursing with the nurses involved. All the registered nurses who were identified to have administered the medication to resident #58 during the months of [redacted] entered their missed documentation in the progress note as of May 14th, 2025. 2. All residents have the potential to be affected. A medication audit of all current residents was conducted, and none were found to be affected by this deficient practice. 3. Facility wide education was completed by the Director of Nursing with all nurses prior to their next working shift on the rights of medication administration, proper documentation of medication and documenting within their scope of practice. 4. The Director of nursing/Designee will audit 5 residents medication administration records of residents on high risk medications weekly for 4 weeks then bi-weekly for 2 months for a total of 3 months to ensure that all licensed practical nurses are following the physician orders in accordance with professional standards of nursing practice. The results will be brought to the quarterly Quality Assurance Performance Improvement meeting for further review and recommendations by the Quality Assurance Performance Improvement Committee.	06/03/2025

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F0658 SS = E	Continued from page 4 This deficient practice was evidenced by the following: On 5/09/25 at 11:38 AM, during the initial tour of the [redacted] unit, the surveyor observed Resident #58 in bed with their eyes closed. The surveyor reviewed the electronic medical record (EMR) for Resident #58. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified [redacted] A review of the comprehensive Minimum Data Set, an assessment tool dated [redacted], revealed the resident had a Brief Interview for Mental Status of [redacted], indicating the resident was [redacted]. A review of the individual comprehensive care plan (ICCP) revealed a focus of [redacted] status r/t (related to) [redacted], [redacted] Date Initiated: [redacted]. Further review of the ICCP revealed a focus of being on [redacted] Date Initiated: [redacted] with an Interventions of "DO NOT [redacted] A review of the Order Summary Report revealed the following PO's: [redacted]. MUST BE CHANGED BY AN [redacted]). in the afternoon. Order Date- [redacted];D/C (Discontinued) Date [redacted] [redacted]. MUST BE CHANGED BY AN [redacted] one time a day. Order date [redacted]; D/C date:	F0658	Continued from page 4 The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	

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F0658 SS = E	Continued from page 5 [redacted] [redacted] ON 7-3 SHIFT UPON COMPLETION. MUST BE CHANGED BY AN[redacted]. every day shift for[redacted] use. Order date[redacted]. A review of the[redacted] Medication Administration Records (MARs) revealed the following: -LPN #1 signed the MARs on[redacted], and[redacted] with a check and her initials. A review of the Chart Codes revealed a check=administered. -LPN #2 signed the MARs on[redacted] with a check and her initials. -LPN #3 signed the MARs on[redacted] with a check and her initials. -LPN #4 signed the MARs on[redacted] with a check and her initials. A review of the[redacted] MARs revealed the following: -LPN #4 signed the MARs on[redacted] and[redacted] with a check and her initials. -LPN #5 signed the MARs on[redacted] with a check and her initials. A review of the progress notes did not reveal a progress note that the[redacted] administered the medication on the above mentioned dates. On 5/13/25 at 1:00 PM, the surveyor interviewed the[redacted] who stated the[redacted] had to be changed by an[redacted] because it was a[redacted] medication and it was the facility's protocol. She stated that if a nurse signed the MARs with a check, it meant the order was administered and completed by the person who signed it.	F0658		

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F0658 SS = E	Continued from page 6 On 5/13/25 at 1:30 PM, the surveyor interviewed LPN #4, who stated she was Resident #58's U.S. FOIA (b)(6). She stated the resident was on NJ Exec Order 26.4b(1) and when it (NJ Exec Order 26.4b(1)) had to be changed, she would call the U.S. FO. She stated if the U.S. FO changed the NJ Exec Order 26.4b she (LPN #4) would sign the MARs that it was done. When the surveyor asked what it meant to sign the MARs, she stated that "I gave the medicine." She could not speak to why she signed the MARs but did not administer the medication. LPN #4 stated that she had not received an inservice on the NJ Exec Order 26.4b(1). On 5/13/25 at 2:13 PM, the surveyor interviewed the U.S. FOIA (b)(6), who stated a check mark with initials on the MAR meant it (the medication) was administered and completed by the person signing it. He stated that a NJ Exec Order 26 medication included NJ Exec Order 26. He confirmed if a PO read "a U.S. FO then it meant it must be done by an U.S. FO and it had to be performed by an U.S. FO." A review of the facility's policy "High Risk Medications" date implemented 1/1/20 revealed: Policy: This facility recognizes that some medications are associated with greater risks of adverse consequences than other medications ...This policy addresses the facility's collaborative, systematic approach to managing high risk medications for efficacy and safety ...Policy Explanation and Compliance Guidelines: 2. The facility will obtain and document specific parameters for administration or withholding certain high-risk medications (e.g. inulin, anticoagulants, certain cardiac medications) as per the physician's or practitioner's orders. NJAC 8:39-29.2(d)	F0658		
F0755 SS = E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F0755	1. Resident #173 is no longer at the facility. Resident #110 was not negatively affected by this deficient practice. RN#1 was immediately educated on the proper technique for the administration of NJ Ex Order via NJ Ex Order 2. All residents with orders to receive NJ Exec Order 26.4b have the potential to be affected by this deficient practice. All residents have the potential to be affected by the deficient practice of untimely administration of medication.	06/03/2025

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F0755 SS = E	Continued from page 7 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: COMPLAINT #NJ00183738 Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards by not ensuring; a.) timely administration and accurate documentation of a medication ([redacted]) for one (1) of 12 residents, (Resident #173), reviewed for medication management for 14 out of 50 doses and b.) proper technique was performed for administration of an [redacted] by one (1) of three (3) nurses who administered medications to one (1) of five (5) residents, (unsampled Resident #110), during the medication administration observation. The deficient practices were 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	F0755	Continued from page 7 3. The Assistant Director of Nursing completed education/training with every nurse prior to their next shift of work on the proper technique of insulin administration, timely administration and documentation of medication. Facility Medication Administration policy updated to include process for what to do when timely administration is not possible. Technique for insulin pen administration was added to be part of the nurses orientation process to capture every nurse upon hire. As part of the nursing orientation the nurses are educated on the timely administration and documentation of medication including what to do if timely administration of medication is not possible. 4. The Director of nursing/Designee will audit 5 residents medication administration records weekly for 4 weeks then bi-weekly for 2 months for a total of 3 months to ensure that all medication are administered in a timely manner according to physician order. The results will be brought to the quarterly Quality Assurance Performance Improvement meeting for further review and recommendations by the Quality Assurance Performance Improvement Committee. The Director of nursing/Designee will observe the administration of insulin via insulin pen on two residents weekly for 4 weeks, then bi-weekly for 2 months for a total of 3 months to ensure proper technique for administration of insulin via insulin pen. The results will be brought to the quarterly Quality Assurance Performance Improvement meeting for further review and recommendations by the Quality Assurance Performance Improvement Committee. The Quality Assurance Performance Improvement Committee will determine whether the audit and observation need to be continued or discontinued.	

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F0755 SS = E	Continued from page 8 nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." 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 case finding; 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." 1. The surveyor reviewed the medical record for Resident #173. A review of the Admission Record revealed diagnoses which included, but not limited to, NJ Exec Order 26.4b1 [redacted] A review of the NJ Exec Order 26.4b1 electronic medication administration records (EMARs) revealed a physician's order (PO) dated NJ Exec Order for NJ Exec Order 26.4b1 [redacted]." The time of administration indicated was 9AM and 9 PM. The EMARs indicated the NJ Exec Order 26.4b1 was not administered and designated with the number [redacted] which correlated to "other/see nurses notes" for the 9AM doses on NJ Ex Order 26 and NJ Ex Order 2 and for the 9 PM doses on NJ Ex Order 26 and NJ Ex Order 26. A review of the nursing progress notes revealed the following for the corresponding dates and times of NJ Exec Order 26.4b1 administration for the dates and times above:	F0755		

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F0755 SS = E	Continued from page 9 -on NJ Ex Order 26 at 9:24 PM the nurse documented "not available." -on NJ Ex Order 26 at 12:29 PM the nurse documented "awaiting for pharmacy to deliver." -on NJ Ex Order 26 at 10:20 PM the nurse documented "not available." -on NJ Ex Order 2 at 8:11 AM the nurse documented "ordered." There were no progress notes indicating that the physician was contacted regarding the NJ Exec Order 26.4b1 not being administered. Further review of the NJ Exec Order 26.4b1 EMARs indicated the NJ Exec Order 26.4b1 times for administration were 9 AM and 9 PM and was documented as administered from NJ Ex Order 26 until NJ Ex Order 26 (except for 9 AM on NJ Ex Order as noted above). A review of the Medication Admin (Administration) Audit Record (a report that identifies the actual electronic time stamp of administration that a medication was administered) revealed that NJ Exec Order 26.4b1 was administered outside of the acceptable timeframe for medication administration for 10 out of 50 doses. The 9AM time for NJ Exec Order 26.4b1 had actual administration times as follows: -on NJ Ex Order 26 the administration time was 11:50 AM. -on NJ Ex Order 26 the administration time was 11:01 AM. -on NJ Ex Order 26 the administration time was 11:16 AM. -on NJ Ex Order 26 the administration time was 10:48 AM. -on NJ Ex Order 26 the administration time was 10:11 AM.	F0755		

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F0755 SS = E	Continued from page 10 -on [redacted] the administration time was 11:07 AM. -on [redacted] the administration time was 10:53 AM. -on [redacted] the administration time was 10:21 AM. -on [redacted] the administration time was 10:34 AM. -on [redacted] the administration time was 10:37 AM. There were no progress notes indicating the reason the [redacted] was administered late or that the physician was contacted regarding the late administration times for the above dates and times. On 5/13/25 at 12:47 PM, the surveyor interviewed the [redacted] via telephone who stated that she was a [redacted] r. The [redacted] stated that if there was a concern expressed by a resident or family member regarding medications or late medications then she would have to get the specific concern and follow up. The [redacted] added that she would make a report and document electronically in the progress notes. The [redacted] also stated that there was a complaint form available if any resident or family member wanted to complete or she would complete it, and the report would go to the [redacted] especially because she only worked [redacted] and the [redacted] would have to follow up. The [redacted] added that if there were late medications then she would first check the medication list and times that the medications were due because the nurses were allowed to administer medications between one (1) hour before and one (1) hour after the time of administration indicated on the EMAR. The [redacted] also stated that the nurses would have to make her aware if there was an issue with medications and was unable to recall any time from [redacted] that there was an issue with medications being administered late. The [redacted] added that she would remember if there was an issue with late medications because she would have had to help administer medications so that the medications were all administered and not late and would document the issue. The [redacted] was [redacted] to any concerns regarding Resident #173. On 5/13/25 at 2:35 PM, the surveyor interviewed the	F0755		

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F0755 SS = E	Continued from page 11 U.S. FOIA (b)(6), who stated that if he had observed medications being administered late during a medication administration observation, he would have to follow up with the U.S. FOIA (b)(6) to see if there was an emergency or what was the cause of the problem. The U.S. FO added that if a resident was unable to receive their medications within the allowed timeframe usually the physician should be contacted and made aware but was unsure of the facility policy. On 5/14/25 at 2:39 PM, the survey team met with the U.S. FOIA (b)(6). The U.S. FOIA stated there was documentation that the resident refused the NJ Exec Order 26.4b1 as indicated on the EMAR and provided documented refusals in the progress notes. The U.S. FOIA then stated she would have to review the Medication Admin Audit Report for the late administration times for NJ Exec Order 26.4b1. A review of the EMARs and progress notes for the dates and times of refusals of the NJ Exec Order 26.4b1 had not correlated to the late administration dates and times. On 5/15/25 at 11:28AM, the survey team met with the U.S. FOIA (b)(6). The U.S. FOIA stated that she had reviewed the EMARs and Medication Admin Audit Report and was able to call four (4) nurses who had signed the EMAR for 9 AM and the Medication Admin Audit Report indicated a late administration time. The U.S. FOIA added that the nurses had told her that Resident #173 NJ Exec Order medications at times and would take the medications later. The U.S. FOIA also stated that the nurses had said a family member would visit usually around 11 AM to 12 PM and that's when the resident would take the NJ Exec Orde The U.S. FOIA stated that she thought the nurses could indicate on the EMAR NJ Exec Order and then when the resident took the medication could NJ Exec Order 26.4b1 and indicate medication was administered. The U.S. FOIA stated she would expect the nurses to notify the physician and document when a medication was late in the progress notes. The U.S. FOIA added the physician should be called because the PO had twice a day dosing and would need to review if the time was too close and a PO would have to be obtained to administer the medication at a different time. The U.S. FOIA acknowledged that there was no documentation explaining the late time of administration or that the physician was notified.	F0755		

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F0755 SS = E	Continued from page 12 On 5/15/25 at 12:06 PM, the surveyor interviewed the U.S. FOIA, who stated the current policy for Medication Administration had not addressed what the nurses were to do when medications were administered late or refused. The U.S. FOIA also stated that he would expect documentation of refusals, late medication administration and notification to the physician in progress notes. The U.S. FOIA acknowledged the nurses had not followed the PO. A review of the facility policy with a date implemented of 1/1/2020, titled "Medication Administration" provided by the U.S. FOIA reflected that medications were to be administered as ordered by the physician and in accordance with professional standards of practice. In addition, the policy revealed "Policy Explanation and Compliance Guidelines" to ensure that the six rights of medication administration are followed which included "right time" and "Right documentation" and "Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician." 2. On 5/12/25 at 8:17 AM, the surveyor observed the Registered Nurse (RN#1) preparing to administer NJ Exec (NJ E medications to an unsampled resident (Resident #110) which included NJ Exec Order 26.4b1 in a NJ Exec Order 26.4b1. The surveyor observed RN #1 place a NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1, which had an opened date of NJ Ex Order written on the label. On 5/12/25 at 8:24 AM, the surveyor observed RN #1 enter Resident #110's room with the NJ Exec Order 26.4b1 and obtained a NJ Exec Order 26.4b1 result of NJ Exec using a NJ Exec Order 26.4b1. The surveyor observed Resident #110 in bed with a breakfast tray on the overbed table. Resident #110 stated that they had not started to eat yet. RN #1 stated that the resident had a standing physician's order (PO) for NJ Exec Or NJ Exec Order 2 to be administered and NJ Exec Or the NJ Exec Order 26.4b1 to NJ Exec On 5/12/25 at 8:26 AM, the surveyor observed RN #1 NJ Exec Order 26.4b1 into Resident #110's NJ Exec O The surveyor NJ Exec Order 26.4b1 as the RN #1 NJ Exec Order 26.4b1 and then observed RN #1 NJ Exec Order 26.4b1 NJ Exec Order 26.4b1.	F0755		

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F0755 SS = E	Continued from page 13 The surveyor had not observed RN #1 NJ Exec Order 26.4b1 prior to NJ Exec Order the NJ Exec Order 26 On 5/12/25 at 8:45 AM, the surveyor interviewed RN #1, at the medication cart. RN #1 stated that she had worked at the facility for approximately a NJ Exec Order 26.4b1 and knew there was a technique when using the NJ Exec Order 26.4b1 to check if the NJ Exec was working by wasting one NJ Exec O. RN #1 added that she did not have to waste NJ Exe because she asked the previous nurse, and the NJ Exec Order 26.4b1. RN #1 added that after the NJ Exec Order 26.4b1 into the resident, and she only had to hold the NJ Exec Order 26.4b1 in for two (2) seconds. RN #1 stated that she had been trained recently by the U.S. FOIA (b)(6) and was unsure if the U.S. FO had observed NJ Exec Orde being administered by NJ Exec Order 26.4b1 or if the U.S. FO had just reviewed the technique. The surveyor reviewed the medical record for unsampled Resident #110. A review of the most recent quarterly comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated NJ Exec Order 2 reflected the resident had a brief interview for mental status (BIMS) score of NJ Exec Order 26.4b1, indicating that the resident had an NJ Exec Order 26.4b1 A review of the resident's Admission Record revealed diagnoses, which included, but not limited to; NJ Exec Order 26.4b A review of the EMAR revealed a PO dated NJ Exec Orc for 'NJ Exec Order 26.4b1 with a time of administration of 8 AM. On 5/12/25 at 1:40 PM, the U.S. FOIA acknowledged there was a technique for NJ Exec Orde administration via a NJ Exec Order 26.4b1	F0755	N	

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F0755 SS = E	Continued from page 14 and there had been an inservice. A review of an inservice dated [redacted] titled "[redacted] Administration" provided by the [redacted] and had been performed by the [redacted]) instructed [redacted] by turning the dose selector clockwise. With the [redacted], and watch to see at least one drop of [redacted] appears on the [redacted]. If not, repeat until at least one drop appears. Press the [redacted] button to [redacted] Hold the button down while keeping the [redacted] and count to 10. This helps make sure that you receive your [redacted]. After you finish counting, remove [redacted]." A review of the "[redacted] Administration Sign-In Sheet" revealed that RN #1 had not attended the inservice. On 5/12/25 at 3:16 PM, the surveyor interviewed the [redacted] via telephone. The [redacted] stated he had completed medication pass observations and [redacted] technique was listed on his forms. The [redacted] added that if he had not observed an [redacted] being administered then he verbally reviewed the technique with the nurse. The [redacted] also stated that he knew he had recently done a medication observation with RN #1 and thought he had reviewed the technique with her. The [redacted] explained the proper technique for [redacted] was to [redacted] the [redacted] first by wasting [redacted] and after pushing the [redacted] down to make sure to hold the [redacted] in for at least 5 seconds to ensure the [redacted] had been [redacted] A review of a "Medication Pass Observation Worksheet" completed by the CP dated [redacted] reflected RN #1 had a medication observation performed with a "Nurse error rate" of 0%. The worksheet indicated for "Proper technique with [redacted]" there was "N/A" checked (meaning not applicable) and the section "Comments" of the worksheet reflected "Reviewed [redacted] administration, [redacted] handling and [redacted] administration with the nurse." On 5/15/25 at 11:28 AM, the survey team met with the [redacted] The [redacted] acknowledged RN #1 had not performed the appropriate technique for the administration of the [redacted] to ensure the appropriate dose of [redacted] and was inserviced.	F0755		

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F0755 SS = E	Continued from page 15 A review of a policy dated 1/1/20 titled "Insulin Pen" provided by the DON reflected "Policy Explanation and Compliance Guidelines: Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir." In addition, the policy reflected "Procedure: Prime the insulin pen: h. i.Dial 2 units by turning the dose selector clockwise. i.With the needle pointing up, push the plunger, and watch to see at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears." The procedure also included, "j.Injecting the insulin: iv. Fully depress plunger until the dosing numbers count back to zero. v. While still pressing the plunger, keep the needle in the skin for up to 6-10 seconds and then remove the needle from the skin." A review of the manufacturer's specifications for "Instructions for use NJ Exec Order 26.4b1)" reflected that the steps required to properly administer an insulin pen included "Prime before each injection." "Priming your pen means removing the air from the needle and cartridge that may collect during normal use and ensures that the pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin." The instructions also revealed "Step 6: To prime your pen, turn the dose knob to select 2 units. Step 7: Hold your pen with the needle pointing up. Tap the cartridge holder gently to collect air bubbles at the top. Step 8: Continue holding your pen with the needle pointing up. Push the dose knob in until it stops, and "0" is seen in the dose window. Hold the Dose Knob in and count to 5 slowly, You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps 6 to 8." In addition, the instructions for giving the injection reflected "Step 11: Insert he needle into your skin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle." NJAC 8:39-11.2 (b); 29.2(a)(d); 29.3(a)(5)	F0755		

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S0000	Initial Comments No Information	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Complaint #s: NJ00179287, NJ00181477, NJ00181857, NJ00183738 Based on interview and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 48 of 63 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 effective on 2/01/21: 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	S0560	1. 1. The daily staffing schedule was reviewed by the Human resources director to assure the facility is in compliance with the required minimum direct care staff-to-shift ratios. 2. All Residents have the potential to be affected by the deficient practice. 3. The Human Resources Director will continue to post the vacancies on all 3 shifts.¿The Human Resources Director will continue to recruit through online platforms as well as a job fair.¿The Administrator will boost the rate when there is emergency staffing coverage.¿The facility is contracted with multiple staffing agencies for temporary and permanent staffing assistance. Employee Referral Bonus Program in place. bi-weekly meetings are held including the Administrator, Director of Nursing, Human Resources, staffing coordinator, and recruiter to review direct care staffing and develop strategies for recruitment and retention of direct care staff. In the event that we do not have the adequate ratio of staff on schedule or have call outs, the staff on shift are asked to stay for another shift as well as available coverage is requested from the facilities contracted staffing agencies at a boosted rate. 4.The Human resources director or designee will report the findings of completed direct care staff to resident ratio weekly audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	05/31/2025

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

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S0560	Continued from page 1 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. The survey team requested staffing for the weeks from 10/6/24 -10/19/24, 12/1/24 - 12/21/24, 2/16/25 - 3/1/25, and 4/20/25 - 5/3/25. 1. For the 2 weeks of Complaint staffing from 10/06/2024 to 10/19/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -10/07/24 had 14 CNAs for 122 residents on the day shift, required at least 15 CNAs. -10/10/24 had 14 CNAs for 121 residents on the day shift, required at least 15 CNAs. -10/12/24 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -10/13/24 had 13 CNAs for 126 residents on the day shift, required at least 16 CNAs. -10/14/24 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/15/24 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/16/24 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/17/24 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -10/18/24 had 15 CNAs for 130 residents on the day	S0560		

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S0560	Continued from page 2 shift, required at least 16 CNAs. -10/19/24 had 15 CNAs for 129 residents on the day shift, required at least 16 CNAs. 2. For the 3 weeks of Complaint staffing from 12/01/2024 to 12/21/2024, the facility was deficient in CNA staffing for residents on 21 of 21 day shifts as follows: -12/01/24 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/02/24 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/03/24 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/04/24 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/05/24 had 12 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/06/24 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/07/24 had 13 CNAs for 117 residents on the day shift, required at least 15 CNAs. -12/08/24 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/09/24 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/10/24 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/11/24 had 13 CNAs for 125 residents on the day	S0560		

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S0560	Continued from page 3 shift, required at least 16 CNAs. -12/12/24 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -12/13/24 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -12/14/24 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -12/15/24 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -12/16/24 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/17/24 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/18/24 had 13 CNAs for 123 residents on the day shift, required at least 15 CNAs. -12/19/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. -12/20/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -12/21/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs. 3. For the 2 weeks of Complaint staffing from 02/16/2025 to 03/01/2025, the facility was deficient in CNA staffing for residents on 6 of 14 day shifts as follows: -02/16/25 had 11 CNAs for 125 residents on the day shift, required at least 16 CNAs. -02/21/25 had 16 CNAs for 133 residents on the day	S0560		

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S0560	Continued from page 4 shift, required at least 17/ CNAs. -02/23/25 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -02/24/25 had 14 CNAs for 128 residents on the day shift, required at least 16 CNAs. -02/25/25 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -02/28/25 had 15 CNAs for 132 residents on the day shift, required at least 16 CNAs. 4. For the 2 weeks of staffing prior to survey from 04/20/2025 to 05/03/2025, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -04/20/25 had 10 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/21/25 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/22/25 had 14 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/23/25 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/25/25 had 14 CNAs for 127 residents on the day shift, required at least 16 CNAs. -04/26/25 had 15 CNAs for 127 residents on the day shift, required at least 16 CNAs. -04/27/25 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/28/25 had 15 CNAs for 125 residents on the day	S0560		

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S0560	Continued from page 5 shift, required at least 16 CNAs. -04/29/25 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -04/30/25 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. -05/01/25 had 15 CNAs for 125 residents on the day shift, required at least 16 CNAs. On 5/14/25 at 1:02 PM, the surveyor interviewed the staffing coordinator, who stated she was familiar with the New Jersey staffing ratios. She further stated that she only has problems if there were last minute call outs and that it's very rare that they worked short. The surveyor reviewed the facility provided policy "Nursing Services and Sufficient Staff" revised 1/1/25, which included: It is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility's assessment. Policy Explanation and Compliance Guidelines: 1. The facility will supply services by sufficient numbers of each of the following personnel types on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: a. Except when waived, licensed nurses; and b. Other nursing personnel, including but not limited to nurse aides.	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062211	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE , CLARK, New Jersey, 07066

(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
S0560	Continued from page 6 3. The facility is required to provide licensed nursing staff 24 hours a day (except when waived), along with other nursing personnel, including but not limited to nurse aides.	S0560		

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
315341 Y1	A. Building B. Wing Y2	6/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE CLARK, NJ 07066

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 F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 06/03/2025	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
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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 5/15/2025	☐ 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 Y2	DATE OF REVISIT Y3
062211	A. Building B. Wing	6/27/2025

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE CLARK, NJ 07066

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/31/2025	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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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	
5/15/2025	☐ 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
315341 Y1	A. Building B. Wing Y2	6/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE CLARK, NJ 07066

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0607 Reg. # 483.12(b)(1)-(5)(ii)(iii) LSC	Correction Completed 05/31/2025	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 06/03/2025	ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 06/03/2025
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 5/15/2025	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062211 Y1	A. Building B. Wing Y2	6/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE CLARK, NJ 07066

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 05/31/2025	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 5/15/2025	☐ 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 CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/09/25 and 05/13/25. Complete Care at Clark Nursing and Rehabilitation Center was found to be in NON-COMPLIANCE with the 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 Occupancies. Complete Care at Clark Nursing and Rehabilitation Center is a three (3) story, Type II Protected building that was built in March 1995. The facility is divided into 8 smoke zones. The 1st floor has a (10-bed vent unit) with a Type I Essential Electrical System with 2-generators (175 KW and 80 KW). Both units run on diesel fuel. The facility has 140 licensed beds with the current census at 126. The facility has 2-elevators.	K0000		
K0211 SS = F	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 STANDARD is NOT MET as evidenced by: Based on observation and interview on 05/13/2025 in the presence of the[redacted] and the [redacted]), it was determined that the facility failed to ensure that passageways, corridors, exit discharges, exit locations, and access were in accordance with Chapter	K0211	1. All obstructions in the means of egress in the Basement was immediately removed, ensuring that the exit corridor is clear and accessible for residents and staff. 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit monthly for three months to ensure the exit corridor remains clear and accessible. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/05/2025

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0211 SS = F	Continued from page 1 7, and the means of egress of egress was continuously maintained free of all obstructions to full use in case emergency in accordance with NFPA 101:2012 Edition, Sections 7.1.10.1, 19.2.1 and 19.2.2 through 19.2.11. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:38 PM revealed that over 100 foot of the exit access corridor in the basement contained storage on both sides. This storage reduced the clear and unobstructed width to 30-inches, hindering proper access to the exit. In an interview at the time, the [redacted] and the [redacted] confirmed the observation. The facility's [redacted] and the [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.2 (e)	K0211		
K0222 SS = F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs	K0222	1. A readily visible, durable sign that states "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS" was placed on the 3 mentioned delayed egress doors on the second floor. 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit monthly for three months to ensure that all doors equipped with a delayed egress locking arrangement doors will have a sign displayed as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

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K0222 SS = F	Continued from page 2 of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 05/09/2025 and 05/13/2025 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that approved, listed delayed-egress locking systems installed on doors in a required means of egress were in accordance with NFPA 101:2012 Edition, Sections 7.2.1.6.1 and 19.2.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following:	K0222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0222 SS = F	Continued from page 3 An observation on 05/09/2025 at 1:17 PM revealed that the stairway enclosure near room 202 was equipped with a delayed egress locking arrangement. The door was not provided with a readily visible, durable sign that read, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". An observation at 1:19 PM revealed that the stairway enclosure in the second-floor rehab gym was equipped with a delayed egress locking arrangement. The door was not provided with a readily visible, durable sign that read, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". An observation at 1:34 PM revealed that the stairway enclosure near room 231 was equipped with a delayed egress locking arrangement. The door was not provided with a readily visible, durable sign that read, "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS". In interviews at the time, the [U.S. FO] and the [U.S. FOIA (b)] confirmed the observations. The facility's U.S. FOIA (b)(6) and the [U.S. FOIA (b)] were informed of the deficient practices at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.2 (e)	K0222		
K0223 SS = F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke	K0223	1. Necessary parts were ordered and a plan was set to fix the doors missing a self-closing devices or not being able to positive latch. 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit 3 random doors monthly for three months to ensure the self-closure is working properly and that they positive latch 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings.	06/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - MAIN BUILDING 0...** B. WING	**05/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0223 SS = F	Continued from page 4 passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 05/09/2025 and 05/13/2025 in the presence of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) it was determined that the facility failed to ensure that in doors in an exit passageway, stairway enclosure, smoke barrier or hazardous area enclosure were self-closing in accordance with NFPA 7.2.1.8.2, 19.2.2.2.7 and 19.2.2.2.8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 05/09/2025 from 12:48 PM to 1:26 PM revealed: 1. The soiled utility room door near room 320 did not self-close and positive latch when tested. 2. The soiled utility room door in the third-floor nurses' station did not self -close and positive latch when tested. 3. The soiled utility room door near room 220 did not self-close and positive latch when tested. Observation on 05/13/2025 from 12:01 PM to 12:52 PM revealed: 1. The stairway enclosure door near room 114 did not self-close and positive latch when tested. 2. The laundry room door closer was detached and did not self-close and positive latch when tested. Additionally, laundry room door was equipped with a privacy doorknob that impeded egress from the laundry room when tested.	K0223	Continued from page 4 The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

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K0223 SS = F	Continued from page 5 In interviews at the time, the [U.S. FO] and the [U.S. FOIA (b)] confirmed the observation. The facility's [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)] were informed of the deficient practices at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.2 (e)	K0223		
K0293 SS = F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 05/09/2025 and 05/13/2025 in the presence of the [U.S. FOIA (b)(6)] and the [U.S. FOIA (b)(6)], it was determined that the facility failed to ensure that exit and directional signs were displayed in accordance with NFPA 101:2012 Edition, Section 7.10. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations revealed that when exiting the "High Side" on floors 1, 2 and 3 and heading toward the "Low Side", a directional exit sign readily visible from any direction of exit access was not provided. In interviews at the time, the [U.S. FO] and the [U.S. FOIA (b)] confirmed the observations. The facility's [U.S. FOIA (b)(6)] and the	K0293	1. Proper exit signage was installed on floors 1,2, and 3 to assure when exiting the "High Side" and heading toward the "Low Side", a directional exit sign is readily visible from any direction of exit access. 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit monthly for three months to ensure the proper exit signage is placed in the hallways. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE , CLARK, New Jersey, 07066

(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
K0293 SS = F	Continued from page 6 U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.1(c), 31.2 (e)	K0293		
K0341 SS = F	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 STANDARD is NOT MET as evidenced by: Based on observation and interview on 05/09/2025 and 05/13/2025 in the presence of the U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that smoke detection was provided at the Fire Alarm Control Panel (FACP) in accordance with NFPA 101:2012 Edition, Section 9.6.1.8.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:30 PM revealed that the Fire Alarm Panel was in the basement's sprinkler room. The sprinkler room is not a continuously occupied area and automatic smoke detection was not installed to provide protection of the fire alarm system. In an interview at the time, the U.S. FO and the U.S. FOIA (b) confirmed the observation. The facility's U.S. FOIA (b)(6) and the U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 05/13/2025 at 2:30	K0341	An automatic smoke detection was installed to provide continues monitoring to the fire alarm panel room. 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit monthly for three months to ensure the fire alarm panel room has a smoke alarm. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/05/2025

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K0341 SS = F	Continued from page 7 PM. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 72	K0341		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 05/09/2025 and 05/13/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that the inspection, testing and maintenance of the fire alarm system was conducted in accordance with NFPA 101:2012 Edition, Section 9.6.1.3, 9.6.1.5, and NFPA 72: 2010 Edition, Section 14.4.5. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 05/09/2025 revealed that the semi-annual fire alarm inspections conducted on 09/11/24 and 04/15/2025 indicated that electro-mechanical releasing devices were not inspected at least annually as required by NFPA 72. In an interview at the time, the U.S. FOIA (b) confirmed the record review. The facility's U.S. FOIA (b)(6) [redacted] and the U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM.	K0345	1. A electro mechanical releasing devices inspection was completed on 6.5.25 2. Staff and all Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit the life safety binder monthly for three months to ensure there is an annual electro mechanical releasing devices inspection in place on an annual basis. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued	06/05/2025

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K0345 SS = F	Continued from page 8 N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 72	K0345		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 05/13/2025 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6)), it was determined that the facility failed to ensure that sprinkler heads and their frangible bulbs were free of foreign materials in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8 and NFPA 25:2012 Edition, Section 5.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 12:49 PM revealed that 2 of 2 sprinkler heads in the dryer area of the laundry room had a heavy loading of foreign material. In an interview at the time, the U.S. FOIA (b) confirmed the observation.	K0353	1. The two sprinkler heads in the dryer area of the laundry room were cleaned of any foreign material. 2. All residents have the potential to be affected by the deficient practice. 3. The Maintenance Director or designee will audit monthly for three months to ensure that the sprinkler heads are free of foreign material. 4.The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/05/2025

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K0353 SS = F	Continued from page 9 The facility's U.S. FOIA (b)(6) and the U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.1(c), 31.2 (e) NFPA 25	K0353		
K0363 SS = F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.	K0363	1. Necessary parts were ordered and a plan was set to fix the doors that did not positive latches as well as any gaps when the doors are closed. 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit 3 random doors monthly for three months to ensure the self-closure is working properly and that they positive latch. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/06/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING **01 - MAIN BUILDING 0...** B. WING	**05/15/2025**

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K0363 SS = F	Continued from page 10 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 05/09/2025 and 05/13/2025 in the presence of the U.S. FOIA (b)(6) [redacted] it was determined that the facility failed to ensure that doors in the corridor were: a) capable of being closed and maintained closed against the force of 5-lb applied at the latch edge of the door and b) able to resist the passage of smoke in accordance with NFPA 101:2012 Edition, Sections 19.3.6.3.2 and 19.3.6.3.5. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 05/09/2025 from 12:53 PM to 1:44 PM revealed: 1. Resident room 329 door did not positive latch when tested. 2. The third-floor nourishment room, third-floor employee restroom and second floor nourishment room did not positive latch when tested. 3. The second-floor beauty parlor door had a 1/2-inch gap between the top of the door and the door frame. Observations on 05/13/2025 from 11:35 AM to 2:00 PM revealed: 1. Resident room 103 had a 1/2-inch gap between the top of the door and the door frame. Additionally, the door did not positive latch when tested. 2. The door to the central supply storage room had a 3/4 -inch gap between the meeting edges of the doors. 3. Resident room 305, 316 and 202 had a 1/2 -inch gap between the top of the door and the door frame. In interviews at the time, the U.S. FO and the U.S. FOIA (b) confirmed the observations.	K0363		

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K0363 SS = F	Continued from page 11 The facility's U.S. FOIA (b)(6) and the U.S. FOIA (b) were informed of the deficient practices at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.2 (e)	K0363		
K0374 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 05/13/2025 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) it was determined that the facility failed to ensure: A) when a pair of cross-corridor smoke barrier doors swing in the same direction and are equipped with an astragal edge, a door coordinator was provided and B) doors in smoke barriers were self-closing or automatic-closing in accordance with NFPA 101:2012 Edition, Sections 19.3.7.6, 19.3.7.8 and 19.3.7.9. These deficient practices had the potential to affect all residents and was evidenced by the following: An observation at 11:29 AM revealed that the first-floor smoke barrier doors contained a pair of doors that swung in the same direction in which one door was equipped with an astragal edge. When tested, the door with the astragal edge closed first preventing the other door leaf from closing completely and would allow smoke and gases to pass through. A door coordinator that would prevent the door with the astragal edge from closing first was not provided.	K0374	1. An order was placed for the necessary items to ensure the door with the astragal edge did not close first were ordered. As well as a self-closing device for the basement door. 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit monthly for three months to ensure that the smoke barrier doors are functioning properly with the self-closing feature. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/06/2025

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K0374 SS = F	Continued from page 12 An observation at 12:15 PM revealed that 1 of 2 smoke barrier doors in the basement was not self-closing or automatic closing. The self-closing device was detached from the door. In interviews at the times, the [redacted] and the [redacted] confirmed the observations. The facility's [redacted] and the [redacted] were informed of the deficient practices at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.1(c), 31.2 (e)	K0374		
K0531 SS = F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This STANDARD is NOT MET as evidenced by: Based on record review and interviews on 05/09/2025 and 05/13/2025 in the presence of the [redacted] it was determined that the facility failed to ensure that elevators were inspected, tested and	K0531	1. An annual elevator inspection has been completed on 6.16.25 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit the life safety binder monthly X three months to ensure the annual elevator inspection is up to date. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/17/2025

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K0531 SS = F	Continued from page 13 maintained in accordance with the New Jersey Department of Community Affairs Elevator Safety Division, New Jersey Uniform Construction Code, ASME A17.1/CSA B44, Safety Code for Elevators and Escalators and NFPA 101: 2012 Edition, Sections 19.5.3, 9.4, 9.4.2, and 9.4.6. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review revealed that the latest annual elevator inspection was conducted on 05/03/2024, over a year ago. In an interview at the time, the [redacted] and the [redacted] confirmed the record review. The [redacted] stated that they contacted the elevator inspection company and it was scheduled for some time in August. The facility's [redacted] and the [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.2 (e) ASME A 17.1/CSA B 44	K0531		
K0911 SS = F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview on 05/13/2025 in the presence of the [redacted]) and the [redacted] it was determined that the facility failed to ensure that electrical panels were guarded to prevent unauthorized access, tampering, or potential hazards in resident	K0911	1. The electrical panel was mmediately locked. 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit monthly for three months to ensure the electrical panel is locked. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/03/2025

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K0911 SS = F	Continued from page 14 accessible areas in accordance with NFPA 101: 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99: 2012 Edition, Section 6.3.2.1, 6.3.2.2.1.3 (A), 15.5.1.2 and NFPA 70: 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 11:54 AM revealed that 3 of 3 electrical panels near the 1st floor nurse's station were left unlocked. In an interview at the time, the [redacted] and the [redacted] confirmed the observation. The facility's [redacted] and the [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.2 (e) NFPA 99	K0911		
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are	K0918	1. We educated the [redacted] to schedule the monthly generator tests every 30 days. The annual generator fuel test was conducted on 4.22.25. The vendor is scheduled to replace the batteries of the 175KW generator to maintenance free batteries on 6.10.25 2. All Residents have the potential to be affected by the deficient practice. 3. The Maintenance Director, or designee will audit the life safety binder monthly for three months to ensure the correct battery is in the generator, annual fuel sample in place, as well as a monthly generator test. 4. The Maintenance Director or designee will report the findings of these audits to the Nursing home administrator as well as at the quarterly Quality Assurance and Performance Improvement meetings. The Quality Assurance Performance Improvement Committee will determine whether the audit needs to be continued or discontinued.	06/05/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE , CLARK, New Jersey, 07066

(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
K0918 SS = F Bldg. 01	Continued from page 15 inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on record review, observations and interviews on 05/09/2025 and 05/13/2025 in the presence of the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) , it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance (ITM) of the emergency generator was in accordance with NFPA 99 :2012 Edition, Section 6.5.4, NFPA 110: 2010 Edition, Sections 8.3.1, A 8.3.1(a), A 8.3.1(b) and NFPA 70. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review of the 80 KW and 175 KW emergency generator indicated that monthly load test were conducted: 1. On 08/30/2024 and 09/02/2024, 3 days apart 2. On 11/07/2024 and 12/30/2024, 53 days apart 3. The last documented load test was dated 04/01/2025. The date of record review was 05/13/2025, 43 days prior. In an interview at the time, the U.S. FOIA (b reviewed the monthly load inspections and confirmed the record review. A record review revealed that an annual fuel analysis was not conducted in 2024. In an interview at the time, the U.S. FOIA (b confirmed the	K0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

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K0918 SS = F Bldg. 01	Continued from page 16 record review. An observation on 05/13/2025 at 1:05 PM revealed that the 175 KW emergency generator was provided with a lead acid battery. In an interview at the time, the surveyor requested monthly specific gravity testing. The [redacted] confirmed that the battery was not a sealed lead acid battery and stated that monthly specific gravity testing was not conducted. The facility's [redacted] and the [redacted] were informed of the deficient practices at the Life Safety Code exit conference on 05/13/2025 at 2:30 PM. N.J.A.C 8:39-31.2 (e) NFPA 99, 110	K0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315341	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025

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E0000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E0000		

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 reverse for further 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

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
315341 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/27/2025 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT CLARK LLC	1213 WESTFIELD AVENUE CLARK, NJ 07066

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	06/05/2025	LSC K0222	06/05/2025	LSC K0223	06/17/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	06/05/2025	LSC K0341	06/05/2025	LSC K0345	06/05/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	06/05/2025	LSC K0363	06/06/2025	LSC K0374	06/06/2025
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	06/17/2025	LSC K0911	06/03/2025	LSC K0918	06/05/2025
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 5/15/2025

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