

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315050	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/27/2026
NAME OF PROVIDER OR SUPPLIER Complete Care at Burlington Woods, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 115 Sunset Road Burlington, NJ 08016	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Complaint #2698562Based on interviews, record review of the medical records, and other pertinent facility documents on 1/27/26, it was determined that the facility failed to provide adequate assessment and to provide needed care or services to manage resident's symptoms in accordance with professional standards of practice; after they received report from the resident's family member that the resident had decline in condition. This deficient practice was identified for 1 of 4 residents, (Resident #2) reviewed and was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.According to the admission Record, Resident #2 was admitted to the facility with diagnoses which included but not limited to: Sepsis (a potentially life-threatening condition that arises when the body's dysregulated response to infection causes injury to its own tissues and organs), Chronic Obstructive Pulmonary Disease (a group of lung diseases that cause progressive airflow obstruction and breathing difficulties), Type 2 Diabetes Mellitus (high blood sugar), and Diastolic Congestive Heart Failure (a stiff left heart ventricle).The Minimum Data Set (MDS), an assessment on 10/24/2025, indicated that Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that the Resident's cognition was intact. According to statement written by the Licensed Practical Nurse (LPN #1) indicated, that at approximately at 7:30pm, the resident's family who was visiting with the resident, came to the nursing station and told LPN #1 that the resident looked septic. According to the progress note (PN) written by LPN #1, dated 10/28/25 at 2220 (10:20PM), LPN #1 notified the Nursing Supervisor of the family's report and the supervisor assessed the resident, and obtained vitals as follows: Blood Pressure 142/101, Heart Rate 126, Pulse Oximetry 97 and Blood sugar of 438, Temperature 98.1 and Respiratory Rate of 17. The PN stated that the Medical Doctor was notified. LPN #1 documented in the PN that the resident's family insisted to send the resident to the hospital. The PN stated that 911 was called, all resident information was given to them, resident was taken to the Hospital.On 1/27/26, the Surveyor reviewed Resident #2's Progress Note (PN), and there was no documentation in Resident #2's medical record regarding the Registered Nursing Supervisor's (RNS) assessment findings and how she addressed the resident's elevated blood sugar. There was no documentation regarding the time a physician was notified and what the physician ordered for her to do about the high blood sugar of 438.On 1/27/2026, the surveyor reviewed a document titled: Weights and Vital Summary (a report of vital signs taken) with an effective date range of 10/1/2025 - 1/31/2026 which revealed the following:A review of Resident #2's Weights and Vital Summary under Blood Sugar Summary revealed that on 10/28/25 at 19:54, the resident's blood sugar was 438 mg/dL. The surveyor noted that the</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 315050	Facility ID: 315050 If continuation sheet Page 1 of 3

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident had a standing order for Insulin Lispro Solution 100 UNIT/ML, inject using sliding scale: 151-200=2; 201-250=4; 251-300=6; 301-350=8; 351-400=10; 401-450=12, subcutaneously every 6 hours for Diabetes, with an Order date of 10/17/2025 and D/C (Discontinued) date of 10/29/2025. There was no evidence that staff administered the insulin according to the sliding scale order for the resident's blood sugar level of 438. A review of Resident #2's Weights and Vital Summary under Temperature Summary revealed the last reading was done on 10/28/2025 at 11:30 AM on the 7:00 AM-3:00 PM shift, and it was 98.2 degrees Fahrenheit (forehead (non-contact)); there was no record of another temperature reading that was completed on the report after the resident's family voiced concern to staff. A review of Resident #2's Weights and Vital Summary under Respiration Summary for 10/28/2026 revealed that the last respiration was taken at 11:30 AM on the 7:00 AM-3:00 PM shift, for 18 breaths per minute; there was no record of another respiration that was completed on the report after the resident's family voiced concern. A review of Resident #2's Weights and Vital Summary under Pulse Summary revealed that the last pulse reading was on 10/28/2025 at 11:30 AM on the 7:00 AM-3:00 PM shift, for 108 beats per minute (bpm); there was no record of another pulse reading that was completed on the report after the resident's family voiced concern. A review of Resident #2's Weights and Vital Summary under Oxygen Saturations (O2 Sat) revealed that the last O2 saturation was taken on 10/28/2025 at 11:30 AM on the 7:00 AM-3:00 PM shift, and it was 97% (Room Air); there was no record of another respiration completed on the report after the resident's family voiced concern. A review of Resident #2's Weights and Vital Summary under Blood Pressure Summary revealed that on 10/28/2025 at 18:30 (6:30 PM), the resident's blood pressure was 140/85 mmHg (lying left arm), there was no record of another blood pressure reading that was completed on the report after the resident's family voiced concern. During a telephone interview with the surveyor on 10/28/2025 at 2:43 PM, the Licensed Practical Nurse (LPN #1), stated, I do not remember if any interventions were done prior to the Emergency Medical Services (EMS) arrival. During interview with the surveyor on 10/28/2025 at 5:29 PM, The Registered Nurse Supervisor (RNS) stated that on 10/28/2025, the nurse called her stating that Resident #2's 's family insisted to send the resident to the hospital. The RNS stated that she went to the resident's room and that LPN #1 checked the vital signs while she checked the resident's lung sounds and that the resident's lung sound was diminished and that the resident looked frail. The RNS stated that she could not remember details. When the surveyor asked the RNS where the assessment was documented, she stated that she did not document the assessment, and that she should have documented the assessment so that staff could see the resident's change in condition. During interview with the surveyor on 10/28/2025 at 5:51 PM, the surveyor asked the Director of Nursing (DON) what the expectation of the RNS assessment and documentation was, and she stated that the expectation was that if the supervisor did an assessment, it should have been documented especially if the resident was going out to the hospital. The DON stated that it was important for the supervisor to document so that it was noted that a Registered Nurse (RN) did an assessment, that the doctor and family were made aware, and that she needed to know as well. A review of the Nurse Supervisor Job Description under Specific Job function under Charting and Documentation duties included the following: Documents accurately in resident chart any significant changes in care & services Is responsible for accurate observation, evaluation, and reporting of residents' symptoms, sudden change in .change in conditions and progress to physician . A review of the facility's policy Documentation in Medical Record, with date implemented on 10/1/2024 and date reviewed and revised on 1/26/26, revealed under Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely</p> <p>(continued on next page)</p>		

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