STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315273	A. Building B. Wing	11/21/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Complaint # 2648672Based on observation, interview, and record review, it was determined that the facility failed to: a.) change an arterial ulcer treatment dressing in accordance with a physician order, b.) failed to document appropriately in accordance with professional standards of practice, c) failed to notify the physician that resident refused dressing change. This deficient practice was identified for 1 of 3 residents reviewed with pressure ulcers (Resident #2), and was evidenced by the following:A review of Resident #2's electronic medical record. The admission Record reflected that Resident #2 had diagnoses which included but were not limited to; Polyosteoarthritis, Type 2 Diabetes Mellitus, and Atherosclerosis of native arteries of right leg with ulceration of other part of foot.A review of the comprehensive Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 9/30/25, reflected that the resident had a Brief Mental Status score of 0/15 which indicate that the resident had a severe cognitive impairment. A review of Resident #2's Care Plan revealed an 8/5/25 initiated focus of, The resident has impaired tissue of the 1st and 2nd toes on the right foot. This focus was updated to indicate, 10/14 right 1-4 metatarsal arterial. Interventions included, but were not limited to, cleanse arterial ulcer of 1-4 mtp [metatarsophalangeal; a joint in the foot] nss [normal saline solution] apply dakins [an antiseptic wound cleanser] moist fluffed gauze kerlix bid [twice daily] prn [as needed]. A review of Resident #2's Treatment Administration Record (TAR) dated 10/1/25-10/31/25 revealed an order dated 10/7/25 for: cleanse right 1-4th MTP arterial ulcer with nss apply dakins moist fluff gauze and kerlix bid two times a day and prn . Documentation revealed this order was initialed as being completed on the 10/23/25 evening shift, the 10/23/25 morning shift, and the 10/23/25 evening shift.On 10/24/25 at 9:22 AM, during wound observation tour with the Unit Manager (UM), the surveyor observed Resident #2's arterial wound dressing on Resident #2's right foot was dated 10/22/25 7-3 [initials redacted] On 10/24/25 at 10:00 AM, the surveyor observed the Licensed Practical Nurse (LPN #1) prepare the table for a wound treatment. The LPN completed Resident #2's arterial wound dressing change, then she dated, and signed her initials.In an interview on 10/24/25 at 11:11 AM, the UM confirmed that Resident #2's right foot arterial wound dressing should be changed in the morning and evening of each day, and as needed.A review of the electronic Progress Notes (PN) from 10/22/25 evening shift through 10/23/25 evening shift revealed no documentation of Resident #2's refusal of dressing changes or notification to the physician of the resident's refusal of the dressing changes.In an interview on 10/24/25 at 12:40 PM LPN #2 stated that on 11/23/25 in the morning Resident #2 refused the dressing change. LPN #2 stated that she did not write3 a PN of the resident's refusal. LPN #2 further stated she should have done a PN so that the other nurses would know that the treatment was not done as the doctor had ordered. I made a mistake, I put a check mark, and the treatment was not done.I should have marked refused so the next shift would be aware that the treatment was not done so they could follow up and inform the doctor. I should have informed the supervisor and made the doctor aware.In an interview on 10/24/25 at 12:40 PM, the Director of Nursing (DON) stated that the expectation when the resident refused the treatment was to first retry by making another attempt to do the treatment, then if not successful, document and make the doctor aware that the treatment was not done, to make sure the resident was getting optimal care.During a telephone interview with the surveyor on 10/24/25 at 1:39 PM, the Registered Nurse (RN) reported that on the 10/22/25 and 10/23/25 evening shifts, Resident #2 refused both dressing changes. The RN stated that she coded the wound care for both shifts wrong, and that the process when the resident refused treatment, was to document in the PNs. The RN stated that because it was coded wrong, she did not get the option to document the Resident #2's refusal note. The RN further stated that she did not make anyone, including the doctor, aware that the treatment was not done. The RN stated that for continuity of care and the incoming nurse aware that Resident #2's wound treatment was not done.In an interview on 10/24/25 at 3:15 PM, the Medical Doctor (MD) stated that she was aware that Resident #2 refused treatments at times but was not made aware of their refusals on the 10/22/25 evening shift, the 10/23/25 morning shift, or the 10/23/25 evening shift. The MD stated that the expectation was for the nurses to inform them [medical staff] and they would then reach out to the wound care specialist. The MD stated that the nurses could have also called the wound care specialist and they reach out to them [medical staff]. The MD stated it was important for the nurses to notify the doctor in case of any change in wound status. The MD stated that there was no harm done because the area was gangrenous and a dead area but indicated that not cleaning the wound could cause discomfort to the normal area of skin. A review of the facility policy Documentation of Wound