

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315101	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025
NAME OF PROVIDER OR SUPPLIER Complete Care at Plainfield LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1340 Park 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33106</p> <p>Based on observations, interviews, record review and other pertinent facility documentation it was determined that the facility failed to use appropriate infection control practices to prevent the spread or reduce the risk of infection for a.) provision of wound care for 1 of 2 residents (Resident # 90) reviewed for pressure ulcers b.) proper use of personal protective equipment (PPE) for a resident on enhanced barrier precautions (EBP) for 1 of 1 residents reviewed for EBP, (Resident #8) and c.) properly storing oxygen administration tubing in a protective bag when not in use by the resident for 1 of 2 residents (Resident #70) reviewed for respiratory care.</p> <p>This deficient practice was identified by the following:</p> <p>1.) On 3/13/25 at 10:57 AM, the surveyor observed Resident #90 in the room, sitting up in a chair. The resident stated they had a left heel wound. The surveyor observed the resident wearing pressure reducing booties to the bilateral feet. The resident denied pain or discomfort.</p> <p>On 3/14/25 at 9:11 AM, the resident was observed lying in bed with head of the bed up. The surveyor interviewed the resident at that time and the Resident stated that that they had no concerns. The surveyor observed that the resident was wearing pressure reducing heel boots to the bilateral lower extremities.</p> <p>A review of the Admission Record (AR) (admission summary) indicated that Resident #90 was admitted to the facility with the diagnoses which included but was not limited to; pressure ulcer of the left heel and osteomyelitis (bone infection) of the vertebra.</p> <p>A review of the quarterly Minimum Data Set (MDS) an assessment tool that facilitates a resident's care, dated 12/25/24, indicated the resident had a Brief Interview for Mental Status (BIMS) of 10 out of 15, indicating the resident had moderate cognitive impairment and had an unstageable pressure ulcer.</p> <p>The surveyor reviewed the Treatment Administration Record (TAR) which contained a physician's orders (PO) dated 3/4/25 to apply to the left heel topically on the day shift (7:00 AM-3:00 PM) for wound care of the left heel wound. Treatment consisted of the following steps:</p> <p>1. Cleanse with Dakin's (a dilute solution of sodium hypochlorite (0.4% to 0.5%) and other stabilizing ingredients, traditionally used as an antiseptic, e.g. to cleanse wounds in order to prevent infection) solution.</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
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/14/25 at 10:03 AM, the surveyor interviewed Registered Nurse/Unit Manager (RN/UM #1). The surveyor explained the wound care observations for Resident #90s left heel. RN/UM #1 stated that LPN #1 needed more training related to infection control when performing treatments and should also not date dressings while on a resident because it was a dignity issue. She confirmed that LPN #1 should have disinfected and set up a clean field on the table that she was using to place the treatment supplies. RN/UM #1 stated LPN #1 should not have put an ungloved hand in the package of 4 x 4 gauze dressing because it could contaminate all the dressings in the package. RN/UM #1 also confirmed LPN#1 should not have put gloves in her back pocket before applying them, put the cap to the Santyl in the resident's bed on the bed linen or put the uncapped tube of Santyl with the opening of the tube to lie directly on an uninfected surface. RN/UM #1 added LPN #1 should not have laid the tongue depressor directly on the unclean resident nightstand. She stated that these were all breaks in infection control while performing wound care.</p> <p>On 3/14/24 at 10:30 AM, the surveyor interviewed the facility Infection Preventionist (IP) as well as the Regional Clinical Supervisor (RCS), who confirmed that LPN #1 should have performed hand hygiene and applied gloves before putting her hand in the packet of clean 4 x 4s dressings and should have prepped the nightstand by cleaning with disinfectant and putting down a clean field. The both also confirmed that the tube of Santyl could become contaminated because LPN #1 put the cap of the Santyl in the resident's bed linen and laid the tip of the tubing directly in contact with the uninfected nightstand surface. They both confirmed LPN #1 had multiple breaks in infection control and that the resident's treatment would be re-done immediately.</p> <p>A review of the facility policy, dated 11/2018 and titled, Wound Care indicated that the procedure for wound care was to set up a clean field utilizing a disposable cloth and to place all items to be used during the procedure on the clean field. The policy specified that all clean items were to be on a clean field. The policy indicated that the staff were to wipe nozzles, foil packets, bottle tops etc. with alcohol before opening as necessary. The policy also indicated that after dressing were removed the staff member was to wash hands thoroughly and put on gloves and to wipe reusable supplies with alcohol (outside of containers that were touched with unclean hands) and return to the treatment cart.</p> <p>2.) On 3/13/25 at 12:02 PM, the surveyor observed signage posted on Resident #8's door that the resident was on Enhanced Barrier Precautions (EBP) (an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes). The posting indicated that staff were to wear gloves and isolation gown when performing direct resident care. There was also an isolation caddy hanging on the door which contained, gloves, gowns and mask. The resident was observed out of bed. The surveyor was unable to interview the resident due to the resident having severe cognitive deficits. The resident was observed to be clean and well dressed.</p> <p>On 3/14/25 at 8:56 AM, the surveyor observed Resident #8 in a net bed. The resident was sleeping, and no distress was observed.</p> <p>On 3/14/25 at 8:59 AM, the surveyor observed the Certified Nursing Assistant (CNA) assist the resident out of bed. The signage on the resident's door indicated that a gown and gloves were to be donned (applied) for EBP. The surveyor did not observe the CNA wearing the necessary personal protective equipment (PPE) such as a gown and gloves prior to direct resident care such as transferring the resident from the bed to the chair.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/14/25 at 9:01 AM, the surveyor interviewed the CNA, who stated that the resident required total care and had a gastrostomy tube. The CNA stated that the resident was non-verbal and incontinent of bladder and bowel. The CNA admitted that while performing direct resident care, she was supposed to don a gown and gloves. She stated that it would have been important to wear the proper PPE to protect the resident from infection. She stated she did not apply the PPE because she forgot. She explained that she was educated multiple times on the importance of applying PPE and should follow the directions according to the signage on the resident's door.</p> <p>A review of the AR indicated that Resident #8 was admitted to the facility with diagnoses which included but was not limited to Huntington's Disease (a condition in which nerve cells in the brain break down over time) and gastrostomy (is a surgical procedure for inserting a tube through the abdomen wall and into the stomach used for feeding or drainage).</p> <p>A review of the comprehensive MDS, dated [DATE], indicated that the resident had a BIMS of 00, which indicated the resident had severe cognitive impairment; required maximum assistance with activities of daily living and nutritional needs were met by way of gastrostomy tube.</p> <p>The surveyor reviewed a physician's order dated 5/8/23, that Resident #8 was on enhanced barrier precautions related to (r/t) g-tube (gastrostomy).</p> <p>The surveyor reviewed the resident's Individual Comprehensive Care Plan (ICCP) dated 11/3/23, which reflected the following:</p> <p>Focus: Resident #8 required enhanced barrier precautions related to indwelling medical device: Feeding tube.</p> <p>Interventions:</p> <p>-Clear signage must be posted on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves). For Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. PPE, including gowns and gloves must be available immediately outside of the resident room. [CNA, Nurse]</p> <p>-EBP will be in place for the duration of Resident #8's stay in the facility or until resolution or discontinuation of the indwelling medical device that placed them at higher risk.</p> <p>On 3/14/25 at 11:40 AM, the surveyor interviewed the IP, who confirmed the CNA, who transferred the resident should have worn the appropriate PPE and was required to don a gown and gloves prior to performing direct resident care. Transferring a resident is a form of direct resident care. The IP confirmed that this was a break in infection control and facility policy.</p> <p>The facility policy dated 11/21/2023 and titled, Enhanced Barrier Precautions indicated that EBP would be implemented for any residents with wounds and indwelling medical devices. According to the policy staff were to use PPE-gown and gloves during high contact resident care.</p> <p>44833</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's Oxygen Administration policy with an updated date of 1/2024, did not include procedure to properly store respiratory tubing when not in use.</p> <p>On 3/29/25 at 9:52 AM, the RCS, in the presence of the survey team, provided the surveyor with a revised copy of the Oxygen Administration policy and stated that the facility revised the policy after surveyor inquiry to include: equipment maintenance and storage: . e. keep delivery devices covered in plastic bag when not in use.</p> <p>NJAC 8:39-19.1; 8:39-27.1(e)</p>