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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315110 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/18/2025 |
| NAME OF PROVIDER OR SUPPLIER Complete Care at Wayne Hills Rehab & Resp Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 130 Terhune Drive Wayne, NJ 07470 | |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</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 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p> | <p>Complaint #: NJ00183653 Based on observation, interviews, and review of pertinent facility documents on 07/14/2025, 07/15/2025, and 07/18/2025, it was determined that the facility failed to implement their abuse policy and procedure to ensure all residents were protected from abuse when a cognitively impaired resident (Resident #1) was discovered tied to their wheelchair by their roommate (Resident #3) on 01/15/2025, and the incident was not reported and Resident #1 remained with their roommate until 01/16/2025. This deficient practice was identified for 1 of 7 residents reviewed for abuse (Resident #1). A review of the Facility Reportable Event (FRE), dated 01/17/2025, revealed that Resident #1's Representative (RR #1) reported observing Resident #1 tied to their wheelchair on 01/15/2025. Interview with the Certified Nursing Aide (CNA #1) revealed that on 01/15/2025, when she went to provide incontinence care on Resident #1 prior to bed, she observed Resident #1 tied to their wheelchair by a bedsheet. CNA #1 immediately removed the restraint, and asked who tied the resident up? The resident's roommate (Resident #3) responded, I tied [them] up because [they] keeps roaming in the room touching stuff. CNA #1 did not report the incident to anyone, and Resident #1 remained in the same room as Resident #3 until 01/16/2025, when the Director of Nursing (DON) reviewed RR #1's email and moved Resident #1. The facility's failure to implement their abuse policy including protecting Resident #1 from abuse, and immediately reporting and investigating all allegations of abuse, placed all residents at risk for abuse. This posed the likelihood of serious physical and psychosocial harm, or impairment which resulted in an Immediate Jeopardy (IJ) situation. The IJ began on 01/15/2025, during the 3:00 PM to 11:00 PM shift, after Resident #1 was observed tied to their wheelchair by Resident #3, and CNA #1 did not report the incident leaving the two residents in the same room. The facility was notified of the IJ on 07/15/2025 at 7:30 PM. The facility submitted an acceptable Removal Plan (RP) on 07/17/2025 at 11:01 AM. The survey team verified the implementation of the RP on-site during the continuation of the survey on 07/18/2025 at 1:30 PM. The evidence was as follows:A review of the facility's policy titled Compliance with Reporting Allegations of Abuse/Neglect/Exploitation with an implementation date of 09/1/2024, included Policy: It is the policy of this facility to report all allegations of abuse/neglect/exploitation or mistreatment [...] immediately to the Administrator of the facility. Compliance Guidelines.4. Identification. b. Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment [...] which can include [...] resident to resident altercations. 7. Protection: The facility will protect residents from harm during an investigation.Procedure for Response and Reporting Allegations of Abuse/Neglect/Exploitation.When suspicion of abuse/neglect/exploitation occur, the following procedure will be initiated [...] 1. The Licensed Nurse will: a. Respond to the needs of the resident and protect him/her from further incident. c. Notify the Administrator or designee. The surveyor reviewed the closed medical record for Resident #1. According to the admission Record face sheet (an admission summary), Resident #1 was admitted to the facility with diagnoses which included but were not limited to: acute and chronic respiratory failure with hypoxia (body does not get enough oxygen), generalized muscle weakness, Alzheimer's Disease, and insomnia (sleep disorder with trouble sleeping). According to the quarterly Minimum Data Set (MDS), an assessment tool dated 02/06/2025, Resident #1 had a Brief Interview for Mental Status (BIMS) score of 00 out of 15, indicating the resident was severely cognitively impaired. A review of the Facility Reported Event (FRE) dated 01/17/2025, revealed the following: On 01/16/2025 at 2:30 PM, the DON received an email from RR #1, who stated that Resident #1 was tied to their wheelchair with a blanket during the previous evening shift. RR #1 stated that Resident #1 indicated that it was a [race and gender redacted] who tied them up. The facility interviewed the resident's Licensed Practical Nurse (LPN #1), who stated that RR #1 reported to her on 01/15/2025, that Resident #1 was playing with pants, twisting and making knots, and had shoulder pain. LPN #1 stated that she checked on Resident #1, who was in their wheelchair at bedside, twisting clothes, and she provided the resident with as needed pain medication. The facility interviewed CNA #1, who stated at the beginning of her shift, Resident #1 was observed at bedside in their wheelchair fidgeting with a cloth talking loudly but seemed pleasant. CNA #1 stated at bedtime, she went to provide incontinence care to Resident #1, and the resident was observed in their wheelchair with the flat [bed] sheet tied around them to the back of their chair. CNA #1 stated that she asked out loud who tied [them] to the chair? CNA #1 stated that Resident #1's roommate (Resident #3) replied, I tied [them] up because [they] keeps roaming in the room and touching stuff. The resident [Resident #1] was calm, smiling, and free from pain. The facility indicated that the Social Worker (SW) interviewed Resident #3, who stated</p> | | |