STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315110	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Wayne Hills Rehab & Resp Center	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Complaint # 2687290 Based on interviews, medical record reviews, and review of other pertinent facility documents on 1/29/26, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH), an injury of unknown origin by not reporting a bruise and swelling on the resident's right hand the facility found on 12/1/2025. This deficient practice was identified for 1of 4 residents reviewed (Resident #1) A review of Resident #1's admission Record (AR) revealed that the resident was admitted to the facility with diagnoses that included but was not limited to muscle weakness and functional quadriplegia (unable to move arms and legs).A review of Resident #1's comprehensive Minimum Data Set (MDS), an assessment tool, dated 11/28/25 revealed that resident #1 had a Brief Interview Mental Status (BIMS) score of 9 out of 15, which indicated that the resident was moderately cognitively impaired.A review of Resident #1's care plan dated 12/01/25, revealed a focus care area of swelling and bruising to the resident's right hand.A review of the facility's Reportable Event (FRE) which the facility submitted to NJDOH on 12/05/25, did not address the bruise and swelling on the resident's right hand.On 1/29/26 at 12:52PM, the surveyor conducted an interview with the Director of Nursing (DON) who revealed that the facility could not provide any documented evidence that the identified swelling and bruise on the resident's right hand was reported to NJDOH when they identified the injury on 12/01/25.A review of the facility's policy on Abuse, Neglect and Exploitation with a revised date of 9/01/25 under Reporting Response revealed that the facility will have written procedures that include reporting all alleged violations to the Administrator, state agency, adult protective services and all other required agencies within specific time frames: a) Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious body injury or b) Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serios body injury. NJAC 8:39-9.4(f)

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Complaint #2687290Based on interviews, medical record reviews, and review of other pertinent facility documents on 1/29/26, it was determined that the facility failed to conduct thorough investigations into incidents on 11/27/25 and 12/1/25. This deficient practice was identified for 1 of 4 residents reviewed (Resident #1).The evidence was as follows: A review of Resident #1's admission Record (AR) revealed that the resident was admitted to the facility with diagnoses that included but was not limited to muscle weakness and functional quadriplegia.A review of Resident #1's comprehensive Minimum Data Set (MDS), an assessment tool dated 11/28/25, revealed that Resident # 1 had a Brief Interview Mental Status (BIMS) score of 9 out of 15, which indicated the resident was moderately cognitively impaired.A review of the resident's care plan revealed a focus care area of right hand swelling and bruise, with an initiated date of 12/01/25. A review of Progress Note (PN) dated 11/27/25 at 1:49 PM, written by Registered Nurse (RN) #1, revealed that during incontinent care, the resident was being turned in bed and both of the resident's lower extremities slid off the bed and touched the floor while their upper body remained on the side of the bed.A review of RN #1's statement indicated that the resident was not injured and did not have any signs of pain after the 11/27/26 fall. On 1/29/26 at 12:05PM, the surveyor conducted an interview with the Unit Manager LPN (UM/LPN) about facility process for conducting investigations. She stated that facility process is that the assigned nurse to report the incident to the nursing supervisor who would then obtain witness statements and start the investigation. She further stated that the expectation is that on the day of the incident, all witness statements are obtained, signed and dated by the staff that provided the statements. On 1/29/26 at 12:52 PM, the surveyor conducted an interview with the Director of Nursing (DON), who stated that the incident that occurred on 11/27/25 did not have a separate investigation from the incident that occurred on 12/03/25. The DON also confirmed that the swelling and bruise that was identified on the resident's right hand on 12/01/25, did not have a separate investigation as to how or when the injury occurred. NJAC 8:39-4(f)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #2687290 Based on interviews, medical record reviews, and review of other pertinent facility documentation on 1/29/26, it was determined that the facility failed to a) implement adequate interventions to address the resident's risks for fall, and b) thoroughly assess and monitor a resident following a fall incident on 11/27/25, and after the identification of swelling and ecchymosis [bruise] on the resident's right hand on 12/01/25. According to Facility Reportable Event (FRE), a Licensed Practical Nurse (LPN #1) on the 11- 7 shift on 12/03/25, noticed bruising on the resident's bilateral lower extremities. According to an employee statement, Resident #1 was observed exhibiting signs of pain, and when staff assessed the resident on 12/03/25, the resident flinched like they were in pain. The nursing supervisor's statement indicated she observed bruising on the resident's right and left thigh, their lower back, and that the resident appeared to be in pain. Resident #1 was then sent to the hospital where they were diagnosed with bilateral femur fracture [fracture of both legs]. This deficient practice was identified for 1 of 4 residents reviewed (Resident # 1). The evidence was as follows: A review of the admission Record (AR) for Resident #1, revealed that the resident was admitted to the facility with diagnoses that included but was not limited to acute respiratory failure, muscle weakness, schizoaffective disorder, seizures and functional quadriplegia. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 11/28/25 revealed that Resident # 1 had a Brief Interview Mental Status (BIMS) score of 9 out of 15, indicating that the resident was moderately cognitively impaired. A review of the Facility Reportable Event (FRE) dated 12/05/25, which the facility submitted to the New Jersey Department of Health (NJDOH), stated that while CNA #1 was providing care to Resident #1 on 11/27/25 at 2:40 PM, the resident was squirming and holding the side rail while being turned in bed; and that their lower legs fell off the bed while their torso remained on the bed. According to the FRE, Certified Nursing Assistant (CNA) #1 and a Registered Nurse (RN) #1 repositioned the resident back to bed and assessed the resident. There was no documented evidence that the facility provided interventions to address the fall. The FRE included that on 12/03/25, during the 11-7 shift, Licensed Practical Nurse (LPN) #1 noticed bruising on the resident's bilateral lower extremities. The facility did not address the right hand swelling and bruise on the FRE, and there was no corresponding documentation about the origin of the right-hand injury. The surveyor reviewed the hospital emergency department's x-ray result of the resident's two legs dated 12/4/25 at 4:35 AM, which stated that Resident #1 sustained Acute fractures of the distal shafts of the bilateral femur (fracture of both legs), and that an X-ray of the resident's right hand was done due to: pain, bruising and unsure of trauma. The X-ray result further stated, suspicious for subtle fracture the base of the proximal phalanx (a fracture closest to the hand) of the right third finger. A review of the Nursing Comprehensive assessment dated [DATE], under Mobility, revealed that the resident's mobility was very limited and that the resident was unable to make frequent or significant changes independently. Functional Abilities section revealed the resident was dependent on others for care and for Activities of Daily Living (ADL). The baseline care plan stated that the resident had an ADL deficit. A review of Resident #1's care plan initiated on 11/22/25, included a focus area on risk for falls. The care plan indicated three levels of risks for fall which included: high, moderate or low. The facility did not specify Resident #1's level of risk and did not specify the number of staff needed to assist the resident with repositioning in bed during care. The surveyor reviewed a progress Note (PN) dated 11/24/25 at 1:18 PM, which stated that Resident #1 required total care with 2 assist for repositioning. Another PN dated 11/26/26 at 2:29 PM, stated that the resident required 2 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	assist with care and repositioning. The facility did not include 2 assist requirement in the resident's baseline care plan. An undated employee statement from CNA #1 which was signed by the Assistant Director of Nursing (ADON) did not indicate that the resident had 2 persons helping with their repositioning during care on 11/27/25. The surveyor conducted telephone interview with RN #1 regarding the 11/27/25 incident. She confirmed that she did not assist CNA #1 with repositioning of the resident in bed during the care of Resident #1. She stated that she assessed the resident after the fall and noted no pain. RN#1 did not provide further information regarding follow up interventions to address the resident's fall and did not provide information about the required level of care for the resident. According to the facility's Investigational Summary and Conclusion, the facility stated that they determined the bilateral femur fractures they identified on 12/03/25 resulted from the resident's fall that occurred on 11/27/25. There was no evidence that the facility monitored the resident for pain and injury following the fall on 11/27/25. There were no interventions put in place on 11/27/25 to protect the resident from further fall and injury. The DON during an interview with the surveyor on 1/29/26 at 12:52 PM, she provided no explanation for why the facility's investigational conclusion summary linked the resident's bilateral leg fractures which facility identified on 12/03/25, to the fall that occurred on 11/27/25. The DON did not provide information of how the facility protected Resident #1 from further injury following the fall on 11/27/25 and did not provide information regarding the swelling and bruising on the resident's right hand. The facility's Incident and Accident policy with an implemented date of 9/1/24 and revised date of 10/20/25, under the Policy Explanation .facility will assure that appropriate and immediate interventions are implemented and corrective actions taken to prevent reoccurrences . the policy also stated that they would conduct root cause analysis to ascertain contributing factors . NJAC8:39-33.2 (d)