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	06/12/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interview, and review of other pertinent documents on 6/11/26 and 6/12/26, it was determined that the facility failed to: a) ensure appropriate Enhanced Barrier Precautions (EBP, infection-control measures used in nursing homes to prevent the spread of multidrug-resistant organisms (MDROs)) were followed when Licensed Practical Nurse (LPN #1) was observed to not change gloves before performing closed tracheal suctioning (a sterile, self-contained device that allows healthcare providers to remove airway secretions without disconnecting the patient from a mechanical ventilator), a secondary high-contact task, and artificial airway, such as a tracheostomy), b) failed to ensure LPN #1 changed gloves after accessing a gastrostomy tube, a high-contact task, and before touching the privacy curtains and the window blinds in both Resident #4's and Resident #6's rooms, and c) failed to demonstrate completion of scheduled environmental disinfection of the residents' privacy curtains, in room medical equipment, and terminal room cleanings (a rigorous process, distinctly different from routine daily cleaning) for residents on EBP due to Candida Auris (C. Auris, an emerging, multidrug-resistant fungus (a type of yeast) that presents a serious global health threat) and CRAB (Carbapenem-Resistant Acinetobacter baumannii), an MDRO targeted by the Centers for Disease Control and Prevention (CDC). This deficient practice was evidenced for 2 of 6 residents observed for infection control. This deficient practice was evidenced by the following:A review of the CDC, Clinical Safety: Hand Hygiene for Healthcare Workers, February 27, 2024, Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with: Handwashing with water and soap (e.g., plain soap or with an antiseptic). Antiseptic hand rub (alcohol-based foam or gel hand sanitizer).Cleaning your hands reduces: The potential spread of deadly germs to patients.The risk of healthcare personnel colonization or infection caused by germs received from the patient.Know when to clean hands: Immediately before touching a patient. Before performing an aseptic (free from contamination caused by harmful microorganisms, such as bacteria, viruses, and fungi) task such as placing an indwelling device or handling invasive medical devices. Before moving from work on a soiled body site to a clean body site on the same patient. After touching a patient or patient's surroundings. After contact with blood, body fluids, or contaminated surfaces. Immediately after glove removal.1. A review of Resident #6's admission Record (AR), an admission record summary, revealed that the resident was admitted to the facility with the following diagnoses but are not limited to, anoxic brain damage a severe, (life-threatening condition that occurs when the brain is completely deprived of oxygen, leading to brain cell death within minutes), chronic respiratory failure (a long-term condition where the respiratory system fails to properly oxygenate the blood or remove excess carbon dioxide), resistance to multiple antimicrobial drugs, tracheostomy (a surgical procedure that creates an opening in the neck into the trachea (windpipe)) status, gastrostomy status, and functional quadriplegia. A review of Resident #6's Care Plan Report (CP), revised on 5/14/24, revealed the resident was positive for C. Auris. Interventions included, but were not limited to, EBP to be maintained, monitor lab work per MD order, and staff to wear PPE (Personal Protective Equipment, specialized gear, such as gowns, gloves and masks, worn to minimize exposure to hazards that cause workplace injuries or illnesses) during interactions and during ADLs (Activities of Daily Living) when caring for the resident. On 6/11/26 at 11:02 AM, the surveyor (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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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observed care on the South Wing, a Subacute/Ventilator (a medical life-support machine that mechanically assists or fully controls breathing) Unit of the facility. A loud beeping sound was heard in front of Resident #6's room. The surveyor observed LPN #1 near the room. LPN #1 stated the loud beeping sound indicated that the resident's gastrostomy feeding was completed and the tube need to be flushed with water. On 6/11/26 at 11:05 AM, surveyor observed LPN #1 water to flush the resident's tube. LPN #1 used hand sanitizer, donned (to put on Personal Protective Equipment (PPE), such as Gown, Mask/Respirator, Goggles/Face Shield, and Gloves) on PPE; mask, gown, gloves, and went in the room, drawing the privacy curtain between the two beds. LPN #1 proceeded to flush the resident's gastrostomy tube with water. LPN #1 then suctioned the resident's tracheostomy, wearing the same gloves used to access the gastrostomy tube, before fixing the resident's blanket, closing the window blinds, and opening the privacy curtain.2. A review of Resident #4's AR showed the resident was admitted to the facility with the following diagnoses, but were not limited to, acute (condition that comes on suddenly, has severe symptoms, and typically lasts for a short period of time) and chronic respiratory failure, type 2 Diabetes Mellitus (a chronic metabolic disorder characterized by persistently high blood sugar (glucose) levels), resistance to multiple antimicrobial drugs, muscle weakness, anoxic brain damage, and tracheostomy status. A review of Resident #4's CP, revised on 5/20/26, revealed that the resident required EBP related to indwelling medical devices (feeding tube, tracheostomy tube) and infection or being colonized (the presence and multiplication of microorganisms (like bacteria or fungi) on or in a host without causing disease, tissue invasion, or an immune response) with MDRO, C. Auris. Interventions included, but were not limited to, EBP will be in place for the duration of stay in the facility; PPE must be changed before caring for another resident. On 6/11/26 at 11:20 AM, the surveyor observed LPN #1 in front of their medication cart outside of Resident #4's room. LPN #1 donned their PPE and went in the room with the two cups with water to flush the resident's gastrostomy tube. After flushing the feeding tube with water, LPN #1 then pushed back the privacy curtain and adjusted the window blinds.On 6/11/26 at 12:29 PM, the surveyor interviewed LPN #1, Resident #4's and Resident #6's assigned nurse. LPN #1 stated both residents were on EBP since they were infected with CRAB and their C. Auris infection was colonized. The surveyor asked LPN #1 when staff should change gloves and wash their hands while caring for residents on EBP due to C. Auris and CRAB. LPN #1 stated that after touching the residents' gastrostomy tubes she failed to change her gloves before touching the curtain or blinds. On 6/11/26 at 2:11 PM, the surveyor interviewed the Housekeeping Supervisor (HS). The HS stated there is a weekly schedule to change and wash the privacy curtains, as well as needed, when they are soiled or dirty. The HS further stated devices and equipment, like wheelchairs and transfer lifts, are also cleaned but did not give a frequency for this. The HS stated resident rooms are cleaned. The HS provided sample resident room housekeeping cleaning checklists. The surveyor requested completed forms, but none were provided.On 6/11/26 at 2:34 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), the IP, and the Regional Nurse (RN). The ADON stated facility currently had a total of 19 residents with C. Auris and 11 with CRAB and that all residents were colonized. The ADON further stated all the colonized residents with C. Auris and CRAB were on EBP and located in the Ventilator/Subacute Unit. The ADON stated the changing of gloves should occur after direct contact with a C. Auris and CRAB patient and before touching another object, such as a blood pressure machine, the side of the bed, the curtain, the sinks. The ADON further stated gloves should be changed as well as after touching a contaminated site and before touching an uncontaminated site. On 6/12/26 at 10:00 AM, during entrance conference with the LNHA, ADON, IP, and the Regional Nurse, the surveyor requested documentation of the environmental disinfection and cleaning of resident rooms. The facility provided Isolation Room Cleaning Procedures and a summary of C. Auris training given to housekeeping staff. The survey did not receive documentation environmental disinfection tasks were completed.A review of the facility's policy titled MDRO Infection, with a revised/reviewed date of 10/14/25, revealed under Policy: This facility (continued on next page)

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