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	05/24/2024

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

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on the interview and record review, it was determined that the facility failed to complete and submit electronically the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, within 14 days of completing the resident's assessment and in accordance with the Center's for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. This deficient practice was identified for 1 of 20 residents (Residents #136). This deficient practice was evidenced by the following: On 05/14/24, at 9:41 AM, the surveyor observed Resident #63 lying in bed watching television. The resident was able to answer the surveyor's inquiry. Resident #63's electronic medical record (eMR) revealed the following information: According to the Admission Record (an admission summary) (AR), Resident #63 was admitted to the facility with diagnoses that included but were not limited to urinary tract infections. The Quarterly Minimum Data Set (QMDS), dated [DATE], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored 14 out of 15, which indicates that the resident is cognitively intact. Further review of QMDS with an ARD on 3/22/24 was due to be transmitted to CMS no later than 4/04/24. However, the QMDS was not submitted until 4/26/24. A review of Significant Change MDS (SCMDS) with an ARD on 9/28/23 was due to be transmitted to CMS no later than 10/12/24. However, the SCMDS was not submitted until 10/21/23. A review of the undated Final Validation Report for Resident #36 given by the Regional MDS Coordinator (MDSC) revealed that Assessment Completed Late: Z0500B (assessment completion date) is more than 14 days after A2300 (assessment reference date). On 5/21/24 at 10:01 AM, the surveyor met with the Regional MDSC regarding the late MDS submission but did not provide further information. NJAC 8:39 - 11.2(e)3

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on the interview and record review, it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, in accordance with the federal guidelines for 2 of 20 residents (Resident #63, and #85) reviewed for the accuracy of MDS coding. The deficient practice was evidenced by the following: 1. On 5/14/24, at 9:41 AM, the surveyor observed Resident #63 lying in bed watching television, able to answer the surveyor's inquiry. The resident stated that they had a bowel movement at least once daily and had no problem. Resident #63's electronic Medical Record (eMR) revealed the following information: According to the Admission Record (an admission summary) (AR), Resident #63 was admitted to the facility with diagnoses that included but were not limited to urinary tract infections. The Quarterly Minimum Data Set (QMDS), dated [DATE], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored 14 out of 15, which indicates that the resident is cognitively intact. Section H Bowel Continence is 9. Not rated. The Care Plan initiated dated 1/21/23 revealed under Focus that Elimination: I am totally dependent on staff for incontinent care. On 5/21/24 at 9:53 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who stated that she had returned from maternity leave and could only speak for herself. The March MDS was done by MDSC, who works remotely. The MDSC/RN stated that the resident was incontinent of bowel elimination and added that the MDS was modified from not rated to always incontinent of bowel elimination. The staff was interviewed and found out that the resident was incontinent of bowel elimination and was re-educated regarding the documentation of bowel elimination. On 5/21/24 at 9:14 AM, the surveyor interviewed the Director of Clinical Services (DCS), who said they did the phone interview with the Certified Nurse Assistant (CNA) caring for Resident #63. The CNA stated that the resident had regular bowel movements for at least 1-2 days and added that if the resident went longer than 3 days, she would notify the nurse. The DCS added that the CNA was educated on the importance of documentation. The DCS presented documentation of the interview from the Nurse Practitioner (NP) that she is seeing the resident and asked about bowel movements, and the resident always reports no concern. Upon assessment of the NP, the resident's abdomen is always soft and non-tender, with bowel sounds in all four quadrants. Further review of the QMDS dated [DATE] section J Pain Presence is - Not assessed. The Progress Notes dated 3/18/24 at 4:24 PM stated, No complaint of pain. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Notes dated 3/19/24 at 16:52 stated that there was no complaint. The Progress Notes dated 3/20/24 at 23:24 stated, Denies pain. The Progress Notes dated 3/21/24 at 22:11 stated, No complaint of pain. The electronic Medication Administration Record (eMAR) in March 2024 revealed under Pain assessment every shift stated during the look-back period from March 18 to March 22, 2024, as 0 (zero) or no pain for each shift. Furthermore, the QMDS dated [DATE], section J Fall History on Admission Entry/Reentry, has - Not assessed. The Fall Risk Assessment, effective 3/15/24 at 12:51, was revealed under Fall History stated 1. Choose one of the following: 1. No falls. On 5/21/24 at 9:53 AM, the surveyor interviewed the MDSC/RN, who stated that she usually interviews the resident with the 5-day look back period of the MDS, and another option was looking at the pain assessment done under the assessment tab of the eMR if there's none it could find in the eMAR wherein there's a pain assessment every shift by the nurses. Not assessed means not addressed, and it is an incorrect assessment. She added that the MDSC should interview the resident if there is no assessment for pain or fall. Further review of the QMDS dated [DATE] section M Determination of Pressure Ulcer/Injury Risk under B. Formal assessment instrument/tool (e.g., Braden, [NAME], or other) the answer is B. No. The Braden Assessment, effective 3/22/24 at 10:08, revealed a Braden score of 16 (sixteen) and a low-risk category. The eMAR in March 2024, with an order date of 2/22/24, revealed, Skin check once weekly every day every Thursday document any abnormal finding in progress notes. On 5/21/24 at 9:53 AM, the surveyor interviewed the MDSC/RN, who stated that a Braden and weekly assessment was done on the eMR. The MDS assessment should be accurate, and we are not allowed to include anything if we cannot justify it. On 5/21/24 at 10:00 AM, the Regional MDSC/RN stated that there is a formal assessment done by the NP who comes weekly, and she added that in the eMAR, there is also a weekly skin assessment. 49078 2. On 5/15/24 at 11:34 AM the surveyor interviewed Resident #85. The surveyor asked the resident if they get assistance to use the toilet. The resident stated no that they wear an incontinence brief. The resident also stated that the staff comes to clean and care for him in the mornings, and when they rings the call bell. Resident #85's eMR revealed the following information: (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's AR reflects the resident was admitted with diagnoses including but not limited to Acute Respiratory Failure with Hypoxia (a sudden inability to correctly breathe and related lack of oxygen), and Essential Hypertension (increased blood pressure). An Admission MDS dated [DATE], indicated that the facility assessed the resident's cognitive status using a BIMS. The resident scored a seven (7) out of fifteen (15) which indicated that the resident had severe cognitive impairment. Section H Bowel Continence is 9. Not rated. A Modified MDS dated [DATE], indicated that Section H Bowel Continence is rated 3 (three), which indicates Always Incontinent. The Care Plan initiated dated 4/9/24 revealed under Focus that Elimination: I am totally dependent on staff for incontinent care. A Review of the CNA Documentation Survey Report (documentation that CNA's use for daily tasks) for April 2024 dated 5/22/24 reflects dates 4/18/24 through 4/24/24 are either blank or coded 2 which indicates no bowel movement. A review of Resident #85 nursing progress notes revealed a note dated 4/21/24 that reflected + BM and Incontinent of B & B which reflects a positive bowel movement and that the resident is incontinent of bowel and bladder. NJAC 8:39-33.2(d)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46889 Based on observation, interview, and record review, it was determined that the facility failed to maintain the nursing professional standard of clinical practices by not accurately documenting the bowel elimination status of 1 of the 20 residents (Resident #63) who had been reviewed for urinary catheter. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. The deficient practice was evidenced by the following: On 5/14/24, at 9:41 AM, the surveyor observed Resident #63 lying in bed watching television, able to answer the surveyor's inquiry. The resident stated that they had a bowel movement at least once daily and had no problem. Resident #63's electronic medical record (eMR) revealed the following information: According to the Admission Record (an admission summary) (AR), Resident #63 was admitted to the facility with diagnoses that included but were not limited to urinary tract infections. The Quarterly Minimum Data Set (QMDS), dated [DATE], indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored 14 out of 15, which indicated that the resident was cognitively intact. Section H Bowel Continence is 9. Not rated. A Review of the CNA Documentation Survey Report (documentation that CNAs use for daily tasks) for March 2024, dated 5/20/24, given by the Director of Nursing (DON), reflected that the dates 3/12/24 through 3/23/24 revealed No Bowel Movement. A review of the Progress Notes during the look-back period of March 12 to March 23, 2024, did not reflect the bowel elimination status of Resident #63. A review of the Care Plan initiated dated 1/21/23 revealed under Focus that Elimination: I am totally dependent on staff for incontinent care. On 05/21/24 at 9:34 AM, the surveyor interviewed the CNA regarding the resident's bowel movement schedule. The CNA stated that the resident usually called for help if the resident needed to be changed and the resident ususally had a bowel movement often. She stated that she would document that information into the electronic medical record in the document task. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/21/24 at 9:36 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM), who stated that the resident usually called if they needd to be changed. The RNUM stated that the resident had no problem with bowel movements and they would go regularly. On 5/21/24 at 9:53 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN), who stated that she had returned from maternity leave and could only speak for herself. The March MDS was done by MDSC, who worked remotely. The MDSC/RN stated that the resident was incontinent of bowel elimination and added that the MDS was modified from not rated to always incontinent of bowel elimination. On 5/21/24 at 9:14 AM, the surveyor interviewed the Director of Clinical Services (DCS), who said they did the phone interview with the Certified Nurse Assistant (CNA) caring for Resident #63. The CNA stated that the resident had regular bowel movements for at least 1-2 days and added that she would notify the nurse if the resident went longer than three (3) days. The DCS said that the CNA was educated on the importance of documentation. The DCS presented documentation of the interview from the nurse practitioner (NP), who said that she is seeing the resident and asked about bowel movements, and the resident always reports no concern. Upon assessment of the NP, the resident's abdomen is always soft and non-tender, with bowel sounds in all four quadrants. A review of the policy titled Charting and Documentation, updated in January 2024 under Policy Statement, revealed that All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. NJAC 8:39-27.1(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49078 Based on observation, interview, and review of other pertinent provided facility documents, it was determined that the facility failed to ensure that oxygen care and services were provided according to the standard of clinical practice in one (1) of (1) residents observed for respiratory care. The deficient practice was evidenced by the following: On 5/15/24 at 11:34 AM, the surveyor interviewed Resident #85. During the interview, the surveyor observed that the resident was receiving oxygen by a nasal cannula (a tube attached to an oxygen source that delivers oxygen to the resident via the nostrils). The surveyor observed that the nasal cannula was not positioned in the nostrils of the resident and was located to the left of the resident's nose, on the cheek. Further observation of the oxygen supply tubing revealed that it was attached to a central wall supply and there were no other markings on the tubing or nasal cannula denoting when the tubing and nasal cannula was applied. The resident stated that they are feeling okay with no concerns. On 5/16/24 at 12:55 PM, the surveyor observed Resident #85, in the presence of the Registered Nurse Unit Manager (RNUM). The surveyor and the RNUM observed that the resident's oxygen nasal cannula was not in the resident's nostrils and was located to the left of the resident's nose, on the cheek. They surveyor also observed that oxygen tubing and cannula did not have any markings denoting when it was applied. The surveyor observed RNUM adjust the oxygen nasal cannula on the resident, so it was correctly placed in the resident's nostrils. The RNUM stated she would return with new tubing and a nasal cannula as she could not verify when the tubing and cannula was applied. On 5/16/24 at 12:58 PM, the surveyor interviewed RNUM. The RNUM stated that all oxygen tubing should be dated when it is attached or applied as it is changed weekly or sooner if needed. The RNUM also stated that the nasal cannula should be in nostrils. The surveyor reviewed the electronic medical record (eMR) for Resident #85. The resident's Admission Record, a summary of important information about the resident, (AR) reflects the resident was admitted with diagnoses including but not limited to Acute Respiratory Failure with Hypoxia (a sudden inability to correctly breathe and related lack of oxygen), and Essential Hypertension (increased blood pressure). An Admission Minimum Data Set (MDS), an assessment tool to facilitate care, dated 4/24/24, indicated that the facility assessed the resident's cognitive status using a Brief Interview for Mental Status (BIMS). The resident scored a 7 out of 15 which indicated that the resident had severe cognitive impairment. Section O of the MDS documented the resident received oxygen therapy. The resident's Care Plan, a document that identifies a resident's needs or risks, dated 4/9/24, reflected that the resident had oxygen ordered and was to be provided by nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the resident's Order Summary Report (a list of the resident's medical orders) and the resident's medical order details reflected that the resident had an order to change oxygen tubing and nebulizer equipment every Tuesday 11-7 shift and had orders for oxygen administration. On 5/16/24 at 1:30 PM, the surveyor in the presence of the survey team interviewed the facility administrative team, including Regional Clinical Registered Nurse (RCRN), the Regional Administrator (RA), Director of Nursing (DON) and Administrator. The surveyor informed the facility administrative team of the concerns with the oxygen nasal cannula and the interview with the RNUM. The surveyor reviewed the facility Oxygen Administration policy. The surveyor reviewed the policy which reflected under General Guidelines 1. Line 3, The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. NJAC 8:39-25.2(c)3

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 19106 Based on the interview and record review, it was determined that the facility failed to ensure that the resident's primary physicians a.) signed and dated monthly physician orders and b.) wrote physician progress notes every other month alternating with the nurse practitioner. The deficient practice was observed for 10 of 20 residents (Resident #38, 37, 45, 72, 74, 16, 41, 63, 1, and 78) reviewed and occurred over a 6-month period. The deficient practice was evidenced by the following: 1. A review of the hybrid medical record for Resident #38 revealed the physician electronically signed monthly physician orders for the month of March 2024. There were no other monthly physician orders signed within the past 6 months. Additionally, there were no monthly progress notes written by the physician in the previous 6 months. 2. A review of the hybrid medical record for Resident #37 revealed the physician electronically signed the March 2024 monthly physician orders. There were no other signed monthly physician orders in the past 6 months. Additionally, there were no monthly physician progress notes written by the physician in the previous 6 months. 34033 3. A review of the hybrid medical record for Resident #45 revealed the physician electronically signed monthly physician orders for the month of March 2024. There were no monthly physician orders signed for April and there were previous signed physician orders dated 10/2023. Additionally, there were no monthly progress notes written by the physician in the previous 6 months. 4. A review of the hybrid medical record for Resident #72 revealed the physician electronically signed monthly physician orders for the month of March 2024. There were no other signed monthly physician orders. Additionally, there were no monthly physician progress notes written by the physician in the previous 6 months. 5. A review of the hybrid medical record for Resident #74 revealed there were no monthly physician orders signed after 10/2023. 34421 6. A review of the hybrid medical record for Resident #16 revealed the physician electronically signed monthly physician orders for the month of March 2024. There were no other monthly physician orders signed within the past 6 months. Additionally, there were no monthly progress notes written by the physician in the previous 6 months. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. A review of the hybrid medical record for Resident #41 revealed the physician electronically signed the March 2024 monthly physician orders. There were no other signed monthly physician orders in the past 6 months. Additionally, there were no monthly physician progress notes written by the physician in the previous 6 months. 46889 8. A review of the hybrid medical record for Resident #63 revealed the physician electronically signed the March 2024 monthly physician orders. There were no other signed monthly physician orders in the past 6 months. Additionally, no monthly physician progress notes were written by the physician in the previous 6 months. 48781 9. A review of the hybrid medical record for Resident #1 revealed the resident's primary physician had not hand signed or electronically signed the monthly physician's orders for December 2023, January 2024, February 2024, and April 2024. In addition, a review of the Physician Progress Notes (PPN) revealed that the primary physician did not conduct face to face visits and did not write any progress notes from the months of December 2023 through April 2024. 10. A review of the hybrid medical record for Resident #78 revealed the resident's primary physician had not hand signed or electronically signed the monthly physician's orders for April 2024. On 5/22/24 at 11:14 AM, the surveyor interviewed the RN #2 in the South Wing, who has been working in the facility since 2020. She stated, Dr [name redacted], was here yesterday, he comes three or more times a week and his Nurse Practitioner (NP), [name redacted] also comes. On 5/22/24 at 1:30 PM, the survey team met with the administration: Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Regional [NAME] President of Clinical Services, Director of Clinical Services, to discuss concerns for physician visits and physician signage for monthly orders. Requested for the facility Policy and Procedure for physician visits and physician monthly orders signage. On 5/23/24 at 9:00 AM, the survey team received the facility policies and procedures titled, Physician Orders dated 3/2024 and Physician Visits dated 2/2024. The Physician Orders policy stated, To ensure all medication and treatment orders are received from a credentialed practitioner before implementing. The Physician Visits policy stated, The attending Physician must make visits in accordance with applicable state and federal regulations . at least every 60 days. No additional information was provided by the facility. NJAC 8:39-23.2 (b), 23.2 (d)