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	12/03/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, document review, interviews, and policy review, the facility failed to ensure cold storage areas were clean, the freezer temperature was within standards, expired foods were disposed of properly, the ice machine was cleaned, and the food thermometer was cleaned between use for one of one kitchen and one of two food pantries affecting 84 of 104 residents who consumed food in the facility. This failure had the potential to lead to foodborne illnesses and cross contamination.Findings include: During an observation on 11/30/25 at 8:00 AM, alongside the Dietary Manager (DM), the upright meat cooler had a container of raw meat on an upper shelf- leaking blood throughout, on the right side of the rack. The left side of the white rack had dried pink liquid. The DM stated it was cleaned weekly but should be cleaned right away. The DM moved the leaking meat to the lower shelf in a contained metal pan, along with other raw meat. The DM confirmed it should not have been leaking like that. During an observation on 11/30/25 at 8:06 AM, alongside DM, the upright ice cream freezer had an internal temperature of 20 degrees Fahrenheit (F), verified by the DM. The ice cream containers were observed to be soft, not fully frozen. The DM stated the temperature should have been zero degrees. The three-door upright freezer across from the ice cream freezer had two thermometers. One read eight degrees F, and the other read 12 degrees F. This was confirmed by the DM. The food was observed to be fully frozen. At 8:09 AM, the walk-in freezer was observed to have dirty, rusty racks throughout. The surface was observed to be a non-cleanable surface. The DM stated the rust had been there a while and the racks should have been cleaned weekly. During an observation on 12/02/25 at 8:02 AM, alongside Administrative Assistant (AA) 2, the East Pantry Refrigerator had an 8-ounce whole milk carton, dated 11/30/25, and a mighty shake carton marked with a discard date of 11/12/25. AA2 confirmed the items were expired. The freezer had a pre-packaged container of pulled chicken salsa verde, dated with a best if used by date of 07/25/25. There was a pre-packaged container of gyro slices, with a best by date of 09/14/25. AA2 confirmed they were expired. During an observation on 12/02/25 at 8:33 AM, alongside the DM, the ice machine was dirty along the hard white plastic center piece, inside of the ice machine. It contained a dark brown substance along the bottom edge. The DM confirmed it was dirty and that it had last been cleaned 10/31/25. He stated the ice machine was cleaned monthly. Review of the 2025 Ice Machine Cleaning/ Sanitizing Schedule, provided by the facility, revealed a blank space for November. The most recent date the machine was cleaned was 10/31/25. During an observation on 12/02/25 at 8:42 AM, alongside the DM, the ice cream freezer was eight degrees F, and the ice cream was noted to be soft, not fully frozen. The freezer across from the ice cream freezer was observed at eight degrees F, and the food in the freezer remained frozen. During an observation of lunch preparation and interview on 12/02/25 at 9:08 AM, the Dietary Assistant (DA) 2 was observed to place the thermometer under running water and wipe it with a dry towel. DA2 was observed to place the thermometer into the green beans for temperature, without sanitization. When asked about the process of sanitizing the thermometer, she went to retrieve alcohol pads. At 9:18 AM, DA2 took the thermometer out of the holder without sanitizing it and took the temperature of the green beans. She placed the thermometer back into the holder directly, without sanitizing. She took the thermometer out of the holder again, (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitized it and took the temperature of the mechanical green beans. She placed the thermometer back into the holder directly, without sanitizing. The DM confirmed the staff should have cleaned the thermometer with alcohol pads before taking the temperature and then should have sanitized again after. During an interview on 12/02/25 at 9:47 AM, the Registered Dietitian (RD) stated she conducted monthly kitchen sanitation audits. She stated she did not include the hall pantries in her audit. She was unsure how often the ice machine should have been cleaned. She was unsure of the thermometer sanitization process. Review of the facility's policy titled, Monitoring of Cooler/Freezer Temperature, dated 09/01/25, revealed, All frozen storage must be maintained at or -4 degrees F, unless otherwise specified by law . Refrigerated food shall be labeled, dated, and monitored so that it is used by the use by date . Review of the facility's policy titled, Ice Machines and Portable Ice Carts, dated 09/01/25, revealed Ice machine(s) or carts will be cleaned at any time contamination may have occurred or when visibly soiled.Review of the facility's policy titled, Record of Food Temperatures, dated 09/01/25, revealed Food temperatures will be verified using a thermometer which is both clean, sanitized . NJAC 8:39-17.2(g)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to protect a resident's right to dignity while receiving medication through a gastrostomy tube (G-tube-a tube inserted into the stomach for nutrition and medication) for one (Resident (R) 108) of one resident observed for G-tube medications out of a total sample of 27. This failure placed residents at risk of a diminished quality of life and embarrassment. Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R108 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy (a neurological disorder that affects movement, muscle control, and posture due to brain damage), respiratory failure, and dependence on respirator (ventilator) status.Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 08/28/25 revealed R108 could not be understood and was assessed by staff to be severely impaired in cognition. During an observation on 12/02/25 at 8:59 AM, Registered Nurse (RN) 1 prepared the morning medications for R108 which were to be administered via a G-tube. RN1 entered the room but did not shut the door or pull the curtain to maintain R108's dignity/privacy. R108 was observed lying in bed and wearing a hospital gown. There was no sheet or blanket that covered R108. RN1 lifted R108's hospital gown which revealed his abdomen, the G-tube and R108's brief. RN1 administered the medications to R108 without shutting the door or pulling the curtain.During an interview on 12/02/25 at 9:06 AM, RN1 stated, I should have pulled the curtain or shut the door.During an interview on 12/02/25 at 10:00 AM, the Director of Nursing (DON) was informed of the observation with RN1. The DON stated, She should have either shut the door or pulled the curtain. That is a dignity issue.Review of the facility policy titled, Promoting/Maintaining Resident Dignity, dated 09/01/25, revealed, . It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances residents' quality of life by recognizing each resident's individuality .Maintain resident privacy . NJAC 8:39-4.1(a)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to provide information on the risks and benefits of the use of a wander guard for one (Resident (R)10) of one resident reviewed for elopement in a total sample of 27. This failure placed the residents and/or representatives at risk of not being informed.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a complex mental illness causing disruptions in thought, mood, and behavior) and dementia.Review of the Elopement Care Plan, revised on 02/10/24 and located in the Care Plan tab of the EMR revealed, [R10] is an elopement risk/wanderer. Periods of impaired safety awareness. Interventions included but were not limited to: Wander guard in place to right ankle, dated 05/23/23 and revised on 09/09/25.Review of the Assessments tab and the Miscellaneous tab of the EMR did not show documentation that R10 or his representative were informed of the risks and benefits of the wander guard.Review of the annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 10/23/25 revealed R10 had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated R10 was severely cognitively impaired. R10 had delusions (false beliefs that persist despite evidence to the contrary) and used a wander/elopement alarm.During an observation on 11/30/25 at 3:08 PM, R10 was observed in his bed with a wander guard on his right ankle.During an interview on 12/03/25 at 11:00 AM, the Director of Nursing (DON) was asked if R10 had eloped in the last year. She stated, No.During an interview on 12/03/25 at 12:12 PM, the Assistant Director of Nursing (ADON) stated there was no information provided to the representative on the risks and benefits of the wander guard.Review of the facility policy titled, Elopements and Wandering Residents, dated 09/01/25, revealed, . The facility shall establish and utilize a systemic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, evaluation and analysis of hazards and risks . NJAC 8:39-4.1(a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy review, the facility failed to ensure beds and baseboard heaters were maintained in a safe manner for three of 27 residents (Resident (R) 10, R54, and R13) whose environments were reviewed. This failure had the potential to cause injury.Findings include:1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R10 was admitted to the facility on [DATE] with diagnoses that included dementia.Review of the annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 10/23/25 revealed R10 had a Brief Interview for Mental Status (BIMS) score of seven out of 15, which indicated R10 was severely cognitively impaired.During an observation on 11/30/25 at 10:56 AM, the footboard and headboard of R10's bed revealed exposed plywood which was rough, and the veneer had peeled away revealing sharp edges.2. Review of the admission Record located in the Profile tab of the EMR revealed R54 was admitted to the facility on [DATE] with diagnoses that included dementia.Review of the comprehensive MDS located in the MDS tab of the EMR with an ARD of 09/25/25 revealed R54 had a BIMS score of five out of 15, which indicated R54 was severely cognitively impaired.During an observation on 11/30/25 at 10:58 AM, the footboard and headboard of R54's bed revealed exposed plywood which was rough, and the veneer had peeled away revealing sharp edges.During an interview on 11/30/25 at 11:08 AM, Licensed Practical Nurse (LPN) 4 was shown the beds and confirmed that the veneer was peeling off and they had sharp edges.During an interview on 11/30/25 at 11:12 AM, the Director of Nursing (DON), the Maintenance Director (MD), and Unit Manager (UM) 1 all observed the beds with peeling veneer and sharp edges and confirmed that they needed to be replaced right away.3. Review of the admission Record located in the Profile tab of the EMR revealed R13 was admitted to the facility on [DATE] with diagnoses that included mild dementia with agitation.Review of a significant change MDS located in the MDS tab of the EMR with an ARD of 09/25/25 revealed R13 had a BIMS score of 14 out of 15 which indicated R13 was cognitively intact.During an observation on 12/01/25 at 8:48 AM, the baseboard heating element was pulled away from the wall and was actively putting out heat. The gray metal covering of the heating element was peeling away causing significant sharp edges. R13 stated, It's been like that since I moved into this room.During an interview on 12/01/25 at 8:49 AM, UM1 observed the heating element and confirmed that it was a safety hazard. During an interview on 12/01/25 at 8:57 AM, the Administrator was asked who was responsible for ensuring resident equipment was safe and homelike. The Administrator stated, Maintenance is.Review of the facility policy titled, Safe and Homelike Environment, dated 09/01/24, revealed, . In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment . This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk . NJAC 8:39-4.1(11)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, facility document review, and policy review, the facility failed to provide a notice of transfer to the resident, the representative, and Ombudsman; failed to ensure notices contained information related to the appeals process; and/or failed to record the reason for discharge in a language that could be understood for two of four resident (Resident (R) 8 and R28) reviewed for discharge requirements out of a total sample of 27. These failures had the potential to cause confusion for residents and representatives trying to make informed decisions when residents were transferred to the hospital.Findings include:1. Review of R8's admission Record located under the Profile tab in the electronic medical record (EMR) indicated R8 was originally admitted to the facility on [DATE] with diagnoses of dependence on respirator (ventilator) status, type two diabetes mellitus, and acute and chronic respiratory failure.Review of R8's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 07/21/25 revealed R8 was severely cognitively impaired.Review of R8's Nursing Progress Note, dated 09/16/25 and located under the Progress Note tab in the EMR, revealed, Around 01:50 AM, . Resident was found on the floor, next to the lower position bed. Resident was assessed immediately . Superficial lacerations on the forehead, and 2.5cm [centimeters] abrasion on the right forehead noted. UM [unit manager] and MD [medical doctor] notified. MD orders send Resident to [name of emergency room] for further evaluation .Review of R8's EMR in its entirety and of the facility's binder labeled Transfers, located at the nursing station, revealed no documentation that the facility provided a notice of transfer to R8 and the resident's representative or that the notice was given to the Ombudsman.During an interview on 12/02/25 at 10:14 AM, the Administrative Assistant (AA) 1 stated there should have been a notice of transfer for R8 when she was transferred to the hospital on [DATE]. AA1 stated, The nurses usually fill this [notice of transfer] out and then I fax this to the Ombudsman and send a copy to Admissions. I believe Admissions sends the families a copy of this. AA1 confirmed that there was not a notice of transfer for R8.During an interview on 12/03/25 at 8:50 AM, Licensed Practical Nurse (LPN) 1 stated, I really can't remember if I did the transfer notice or not [for R8]. LPN1 stated she should have filled out a transfer notice and put it on the desk for the unit clerk.2. Review of R28's Face Sheet located under the Profile tab in the EMR indicated R28 was admitted to the facility on [DATE] with diagnoses of acute and chronic respiratory failure with hypoxia, type two diabetes mellitus, and tracheostomy status.Review of R28's quarterly MDS located under the MDS tab in the EMR with an ARD of 10/30/25 revealed R28 was severely cognitively impaired.Review of R28's Nursing Progress Note, dated 11/23/25 and located under the Progress Note tab in the EMR, revealed, . VS [vital signs] obtained BP [blood pressure] 52/30. [name of MD] team contacted. order to transfer resident to ER [emergency room] . Review of R28's Notice of Transfer dated 11/22/25 indicated the reason for transfer was Hypotension, AMS [altered mental status]. The notice of transfer did not have the name or contact information of an entity that the resident representative could contact about appealing the facility's decision to discharge R28 from the facility. During an interview on 12/02/25 at 11:40 AM, the Administrator confirmed that the notice of transfer did not include any entity information other than the Ombudsman to contact in cases when the resident and/or the resident representative wanted to appeal the decision to be discharged when sent to the hospital.During an interview on 12/03/25 at 8:50 AM, LPN1 confirmed the language on the notice of transfer for R28 contained medical terms for the reason of transfer and was not in a language that the resident representative would understand.Review of the facility's policy titled, Transfer and Discharge (including AMA [Against Medical Advice]), dated 03/10/25, indicated, The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include the following at the time it (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is provided: . d. An explanation of the right to appeal the transfer or discharge to the State. e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. f. Information on how to obtain an appeal form. g. Information on obtaining assistance in completing and submitting the appeal hearing request. NJAC 8:39-4.1(a)

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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** Based on record review, interview, and policy review, the facility failed to ensure the accuracy of the Minimum Data Set (resident assessment) related to an antipsychotic medication for one of 27 residents (Resident (R) 75) reviewed creating an inaccurate assessment of the resident's psychological status.Findings include:Review of the admission Record located in the electronic medical record (EMR) under the Profile tab revealed R75 was initially admitted on [DATE] and readmitted on [DATE] with diagnoses that included dementia and schizophrenia.Review of the Physician's Orders located in the EMR under the Orders tab revealed R75 was prescribed quetiapine fumarate (an antipsychotic medication) 50 milligrams (mg) by mouth two times a day for schizophrenia on 09/16/25. Review of the Medication Administration Record (MAR) located in the EMR under the Orders tab, for the month of October 2025, revealed R75 received the antipsychotic medication twice a day as prescribed.Review of the MAR located in the EMR under the Orders tab, for the month of November 2025, revealed R75 received the antipsychotic medication twice a day as ordered until 11/20/25 when she was hospitalized . Upon return to the facility, on 11/24/25, the medication was reduced to one time a day.Review of the quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 11/06/25 revealed R75 was not identified to be taking any antipsychotic medication. During a telephone interview on 12/02/25 at 10:21 AM, the Director of Clinical Reimbursement, responsible for completing the MDS assessments, confirmed that the antipsychotic should have been coded on the MDS as R75 was taking the medication.Review of the facility's policy titled, MDS 3.0 Completion, dated 09/01/25, revealed, Residents are assessed, using a comprehensive assessment process in order to identify care needs and to develop an interdisciplinary care plan. NJAC 8:39-33.2(d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to develop and implement a comprehensive care plan for three of 27 residents (Resident (R) 11, R8, and R65) reviewed. Specifically, the facility failed to develop an individualized activity care plan for R11 creating the potential for individual interests to not be identified; failed to develop an individualized care plan for R8 related to her seizure disorder creating the potential for staff to not respond as needed; and failed to develop an individualized care plan for R65's preference for daily showers creating the potential for showers to be missed.Findings include:1. Review of the admission Record located under the Profile tab in the electronic medical record (EMR) revealed R11 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, anxiety disorder, and major depressive disorder.Review of the quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 09/04/25 revealed a Brief Interview for Mental Status (BIMS) without a score, which indicated R11 was unable to complete the assessment.Review of the 09/09/25 revised comprehensive Care Plan located under the Care Plan tab in the EMR revealed R11, has impaired communication due to diagnosis of anoxic brain damage. Rec [recreation] will visit [R11] daily for social dignity and stimulation. Maintain eye contact with [R11] if possible.Review of the Activity Participation records for October and November 2025, provided by the Activity Director (AD), noted R11 received room visits every morning and afternoon. Each room visit (RV) was coded with a 1, which indicated R11 was not actively involved.During observations on 11/30/25 at 10:17 AM, 12/01/25 at 9:05 AM, and 12/02/25 at 10:53 AM, R11 was in his room, in bed, unable to communicate verbally. R11 was observed to track with his eyes but was unable to consistently blink once for yes or twice for no, when asked.During an interview on 12/01/25 at 11:43 AM, the AD confirmed that she developed the activity care plans. When asked to explain what social dignity and stimulation entailed for R11, the AD said that the activity assistant would go in each morning, say good morning, state the date, weather, holiday, put up a decoration on the wall if applicable, and leave a facility newspaper. When asked what individualized activity plan was in place for R11 who was non-verbal, the AD said the activity assistant would show the resident pictures, provide sensory stimulation, or turn on the resident's television. When asked who provided information about R11's interests prior to the anoxic brain injury which left him non-verbal, the AD said no-one had been contacted for information regarding R11 and what he enjoyed prior to his injury. The AD confirmed that R11 had active involvement from his mother and brother; however, neither had been contacted for information to assist with developing an individualized care plan for R11.During an interview on 12/01/25 at 11:56 AM, the Activity Assistant (Act A) 1 confirmed that he provided the one-to-one interactions with R11. Act A 1 described showing pictures to R11 of animals and offering a smell and tell which was conducted with various smells on cotton balls and telling the resident what the smells were. When asked if he documented the reaction, if any, from R11 during the smell and tell or pictures, Act A 1 said, no. When asked if he contacted R11's family members to obtain prior interests, Act A 1 said, no.2. Review of R8's admission Record located under the Profile tab in the EMR indicated R8 was initially admitted to the facility on [DATE] with diagnoses of dependence on respirator (ventilator) status and seizures.Review of R8's H&P [History and Physical] located under the Progress Note tab in the EMR and dated 10/01/25 indicated, . Seizures: Continue with Keppra [seizure medication] . Review of R8's quarterly MDS located under the MDS tab in the EMR with an ARD of 10/07/25 revealed R8 was severely cognitively impaired.Review of R8's Care Plan located under the Care Plan tab in the EMR revealed there was no plan of care for R8's seizures.The MDS Coordinator was unavailable for interview during the survey.During an interview on 12/03/25 at 12:15 PM, the Assistant Director of Nursing (ADON) confirmed R8 did not have a care plan for seizures. The ADON (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated, Yes, there should have been a care plan for seizures.3. Review of R65's admission Record located under the Profile tab of the EMR revealed an admission date of 08/15/24 with diagnoses which included hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness) affecting left dominant side. Review the Care Plan, dated 10/21/24 and located under the Care Plan tab of the EMR, revealed a focus area of ADLS [activities of daily living]; I require total care for my ADLS including with bathing. Interventions included Provide me with total bed bath every day.Date initiated: 10/21/24. Review of R65's annual MDS with an ARD of 09/11/25 and located under the MDS tab of the EMR revealed a BIMS score of 11 out of 15, which indicated R65 was moderately cognitively impaired. Review of the November 2025 Documentation Survey Report, revealed Shower/ Bathing/ Personal Care was documented as NA [not applicable] on 11/04/25, 11/06/25, 11/10/25, 11/11/25, 11/12/25, 11/13/25, 11/14/25, 11/17/25, 11/19/25, 11/21/25, 11/22/25, 11/23/25, 11/24/25, 11/25/25, and 11/27/25. No showers or baths were listed as being completed according to the care plan. During an interview on 11/30/25 at 10:06 AM, R65 stated he was not getting daily baths. During an interview on 12/01/25 at 11:23 AM, the Certified Nurse Aide (CNA) 5 stated R65's bathing schedule was Mondays and Wednesdays. She stated it would be documented in the medical record. During an interview on 12/01/25 at 12:58 PM, the Director of Nursing (DON) stated she was aware the care plan had daily baths listed for R65. She stated they had been doing audits to ensure the CNA documentation was getting done but had not been checking the documentation for accuracy. Review of the facility's Comprehensive Care Plan policy, dated 02/02/25, revealed, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care . Qualified staff responsible for carrying out interventions specified in the care will be notified of their roles. NJAC 8:39-11.2(e) thru (i)NJAC 8:39-27.1(a)

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	12/03/2025

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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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and policy review, the facility failed to ensure the Fall Care Plan was updated to include interventions to prevent falls after a resident had a fall with major injury for one (Resident (R) 13) of five residents reviewed for falls in a total sample of 27 residents. This failure placed the residents at risk for unmet care needs.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed that R13 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder (a complex mental illness with a major mood disorder) and ataxic gait (abnormal walking characterized by clumsy, staggering, and an uncoordinated walk).Review of the Medical Diagnosis list located in the Diagnosis tab of the EMR revealed, Displaced Fracture of Head of Left Radius, Subsequent Encounter for Closed Fracture with Routine Healing, dated 09/11/25.Review of a significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an Assessment Reference Date (ARD) of 09/25/25 revealed that R13 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R13 was cognitively intact. In addition, R13 had one fall with no injury, one fall with injury, and one fall with a major injury since the previous assessment.Review of the Fall Care Plan, revised 10/30/25 and located in the Care Plan tab of the EMR revealed, Fall Risk: [R13] is at risk for falls r/t [related to] Psychoactive drug use and use of antihypertensive medication. [R13] sustained a fall on 06/13/25 during 7am-3pm shift, no major injuries, 08/14/25 sustained a fall, no injuries, 10/30/25 [R13] sustained a fall, no injuries. It did not document a fall with major injury or updated interventions following the fall. Review of the Pain Care Plan, revised on 09/11/25, revealed [R13] has pain r/t left wrist s/p fall. During an interview on 12/03/25 at 10:23 AM, the Unit Manager (UM) 1 was asked why the Fall Care Plan was not updated/revised to include the fall with fracture on 09/11/25. The UM stated, I am not that good at Care Plans, but I did do a Pain Care Plan for the fractured wrist. UM1 was asked since R13's other falls were listed on the Problem/Focus area why was this fall not listed as a Problem/Focus. UM1 confirmed that the 09/11/25 fall with fracture should have been listed as a Problem/Focus on the Care Plan.Review of the facility policy titled, Comprehensive Care Plans, dated 02/25/25, revealed, . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality . NJAC 8:39-11.2(e)

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and policy review, the facility failed to provide activities to meet the interests or needs of two of 27 residents (Resident (R) 11 and R8) reviewed. The failures created the potential for in-room visits to occur without the residents' individual interests or choice.Findings include:.1. Review of the admission Record located under the Profile tab in the electronic medical record (EMR) revealed R11 was admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, anxiety disorder, and major depressive disorder.Review of the quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 09/04/25 revealed a Brief Interview for Mental Status (BIMS) without a score, which indicated R11 was unable to complete the assessment.Review of the 09/09/25 revised comprehensive Care Plan located under the Care Plan tab in the EMR revealed an R11 has impaired communication due to diagnosis of anoxic brain damage. Rec [recreation] will visit [R11] daily for social dignity and stimulation. Maintain eye contact with [R11] if possible.Review of the Activity Participation records, provided by the Activity Director (AD), for the months of October and November 2025 noted R11 received room visits every morning and afternoon. Each room visit (RV) was coded with a 1, which indicated R11 was not actively involved.During observations on 11/30/25 at 10:17 AM, 12/01/25 at 9:05 AM, and 12/02/25 at 10:53 AM, R11 was in his room, in bed, unable to communicate verbally. R11 was observed to track with his eyes but was unable to consistently blink once for yes or twice for no, when asked. The roommate's television was on. R11 was not observed to have a radio at his bedside, nor was his television on during the observations; only his roommates' television was on.During an interview on 12/01/25 at 11:43 AM, the AD confirmed that she developed the activity care plans. When asked to explain what social dignity and stimulation entailed for R11, the AD said that the activity assistant would go in each morning, say good morning, state the date, weather, holiday, put up a decoration on the wall if applicable, and leave a facility newspaper. When asked what individualized activity plan was in place for R11, who was non-verbal, the AD said the activity assistant would show the resident pictures, provide sensory stimulation, or turn on the resident's television. When asked who provided information about R11's interests prior to the anoxic brain injury which left him non-verbal, the AD said no-one had been contacted for information regarding R11 and what he enjoyed prior to his injury. The AD confirmed that R11 had active involvement from his mother and brother; however, neither had been contacted for information to assist with developing an individualized care plan for R11. When asked if R11 had been identified to enjoy a particular type of music, the AD said she did not know. The AD acknowledged that R11 is a very young man, but did not know what he enjoyed prior to his incident.During an interview on 12/01/25 at 11:56 AM, Activity Assistant (Act A) 1 confirmed that he provided the one-to-one interactions with R11. Act A 1 described showing pictures to R11 of animals and offering a smell and tell which was conducted with various smells on cotton balls and telling the resident what the smells were. When asked if he documented the reaction, if any, from R11 during the smell and tell or pictures, Act A 1 said, no. When asked if Act A 1 contacted R11's family members to obtain prior interests, Act A 1 said, no. When asked if he had provided music to the resident, Act A 1 said, no. No other individualized one-to-one activities were reported to have been offered to R11.2. Review of R8's admission Record located under the Profile tab in the EMR indicated R8 was originally admitted to the facility on [DATE] with diagnoses including dependence on respirator (ventilator) status, type two diabetes mellitus, and acute on chronic respiratory failure.Review of R8's Care Plan located under the Care Plan tab in the EMR indicated a Focus dated 04/18/25, I am not doing the activities I used to enjoy Being [sic] cognitively unable to do them, Decreased physical ability. The intervention indicated, Provide me with tv, music, & or visits to assist me in socialization & dignity.Review of R8's Recreation Quarterly Assessment located under the Assessment tab in the EMR and dated 08/04/25 indicated, Rec (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[recreation] makes social visits for dignity. There was no documentation to reflect the facility had spoken to R8's family to ascertain which TV shows R8 liked to watch or type of music R8 liked.Review of R8's quarterly MDS located under the MDS tab in the EMR with an ARD of 10/07/25 revealed R8 was coded as being severely cognitively impaired.Review of R8's Activity Calendar dated for the months of August through November 2025 indicated RV [room visits] were held with R8. There was no documentation to reflect what activities occurred during these room visits.During an interview on 12/01/25 at 11:44 AM, the AD stated, We just document on the records that they have room visits but not what we do. When asked if she talked with the family to find out what the resident's likes and dislikes were, the AD stated, I have spoken to the sister, but I really don't document each time we talk.Review of the undated facility policy, Meaningful Resident Activities indicated, To provide meaningful activities are provided [sic] as appropriate to the residents [sic] cognitive, physical, and social abilities on a regular basis to enhance their quality of life in and [sic] environment that is near normal as possible and involve the resident in a person-centered care approach. NJAC 8:39-7.4

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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 - Minimal harm or potential for 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** Based on observation, record review, and interview, the facility failed to ensure a resident's room was free of accident hazards for one of 27 sampled residents (Resident (R)8). Specifically, the facility failed to respond timely to a water leak which reached electrical cords to the ventilator, bed, and enteral feeding pump of the resident. This failure had the potential to cause injury or equipment failure. Findings include:Review of R8's admission Record located under the Profile tab in the electronic medical record (EMR) indicated R8 was originally admitted to the facility on [DATE] with the diagnoses of dependence on respirator (ventilator) status and acute and chronic respiratory failure.Review of R8's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 07/21/25 revealed R8 was severely cognitively impaired. R8 had ventilator assistance for breathing and a tube feeding.During an observation on 12/02/25 at 12:45 PM, water from the back of the bathroom sink spilled over into a trash can and then into R8's room. The bathroom was noted to be beside the A bed, by the door. Water was noted to be on the floor underneath the A bed and flowed underneath R8's bed, by the window, where electrical cords from the ventilator, bed, and feeding pump were lying. The surveyor immediately notified Licensed Practical Nurse (LPN) 1 who came into R8's room to assess the situation and then proceeded to obtain the Maintenance Director (MD)'s phone number.At 1:00 PM, when nursing had been unable to reach the MD by phone, there was an overhead page for the MD to come to R8's room. LPN1 directed a Certified Nurse Aide (CNA) to get towels and try to get some of the water off the floor. The CNA laid towels at the bathroom door and then proceeded to go to R8's side of the room and put towels down. At 1:06 PM, the Housekeeping Supervisor (HSKP Sup) came into the room and called the MD on her cell phone. The HSKP Sup stated the MD was not answering the phone in his office and went to see if she could find him. Water was still observed running from the back of the sink and overspilling into the trash can onto the floor.At 1:18 PM, the MD came to R8's room, assessed the sink, and stated there was a valve on the back of the sink where a hose came off. The MD confirmed the water was under R8's bed and the electrical cords to the ventilator, bed, and feeding pump were laying in the puddled water. At 1:30 PM, The MD stated, Everything has been fixed, and the floor is dry. There is no more water under either bed in the room.During an interview on 12/02/25 at 2:45 PM, the Director of Nursing (DON) stated, My expectation was for maintenance to come immediately to the resident's room and stop the water from running out of the bathroom into [R8's] room and for the nurses and CNAs to ensure [R8] was safe.On 12/03/25 at 10:30 AM, the Administrator was asked for a policy to ensure safety of a resident when the electrical cords from the ventilator, bed, and feeding pump cords were laying in water.At 12:30 pm, the Administrator returned to the conference room and stated he was unable to find the requested policy pertaining to that situation. NJAC 8:39-5.1(a)NJAC 8:39-27.1(a)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, record review, interviews, and policy review, the facility failed to ensure a physician order and consent was obtained for bed rail use for one of one resident (Resident (R) 65) reviewed for bed rails out of 27 sample residents. This failure had the potential to affect safety for all residents who had bed rails. Findings include: Review of the admission Record located under the Profile tab of the electronic medical record (EMR) revealed an admission date on 08/15/24 with diagnoses which included hemiplegia (paralysis on one side of the body) and hemiparesis (one sided muscle weakness) affecting left dominant side. Review of the admission Nursing Comprehensive Assessment, dated 08/15/24, and located under the Assessments tab of the EMR, revealed the resident was assessed for bed rail usage, to include proper fit, no gaps between the rails and mattress, and alternatives attemptedReview of the annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/11/25 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated R65 was moderately cognitively impaired. Review of the Orders located under the Orders tab of the EMR revealed no orders for the bed rails. Review of the Care Plan located under the Care Plan tab of the EMR revealed no care plans related to the bed rails.Review of R65's EMR revealed no consents in place for bed rails. During an observation on 11/30/25 at 10:11 AM, R65 was observed to have bilateral bed rails used for mobility. During an interview on 12/03/25 at 8:21 AM, the Rehab Director stated they used the bed rails for residents at fall risk, and they used the Enabler bars for residents who could assist with rolling themselves. During an interview on 12/03/25 at 11:54 AM, the Director of Nursing (DON) stated R65 had Enabler bars and acknowledged there were no orders or consents in place for R65, prior to this date. Review of the facility's policy titled, Bed Rails, dated 09/01/25, revealed, Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted . Upon receiving informed consent, the facility will obtain a physician's order for the use of the bed rail . NJAC 8:39-27.1(a)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, record review, and policy review, the facility failed to ensure medications were administered in accordance with infection control measures for one (Resident (R) 108) of six residents reviewed in a total sample of 27. This failure placed residents at risk of cross-contamination.Findings included.Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R108 was admitted to the facility on [DATE] with a diagnosis of cerebral palsy (brain disorder at birth), respiratory failure, and was ventilator dependent. During an observation on 12/02/25 at 8:59 AM, Registered Nurse (RN) 1 entered R108's room with medications that were placed in four different medication cups for administering through a gastrostomy tube (G-tube-a tube inserted into the stomach to allow for nutrition and medications). RN1 then placed the four cups on an overbed table. She did not use a barrier, nor did she clean the table prior to placing the cups on the table.During an interview on 12/02/25 at 9:06 AM, RN1 was asked why she did not place a barrier down on the table prior to placing the medication cups. RN1 acknowledged that a barrier was not placed or the table cleaned prior to medication pass.During an interview on 12/02/25 at 10:39 AM, the Director of Nursing (DON) was told about the observation. The DON stated, She should have used a barrier as the disposable barriers are located in the cart.Review of the facility policy titled, Medication Administration, dated 09/01/25 revealed, . Medications are administered by licensed nurses, or other staff who are legally authorized to do in this state as ordered by the physician and in accordance with professional standards of practice in a manner to prevent contamination or infection . NJAC 8:39-19.4

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to post the daily staffing report. This deficient practice has the potential to affect all 104 residents and visitors by not accurately informing them of the available nursing staff to care for the residents.Findings include:During an observation on 11/30/25 at 8:00 AM, the New Jersey Department of Health Nursing Home Resident Care Staffing Report was located on a table in the lobby, visible to the public, and noted to have a posting date of 11/28/25. The next posting behind the 11/28/25 one was dated 11/25/25.During an interview on 11/30/25 at 8:30 AM, the Director of Nursing (DON) stated, On the weekends it is not done. The staffing coordinator is the one responsible for placing the staff posting in the lobby, and she does that when she works.During an interview on 12/01/25 at 1:30 PM, the Staffing Coordinator (SC) stated, I do these postings Monday through Friday and then on the weekends, they are not done. I have it on my computer, and I could send it over, but I don't know if the supervisors would know the routine.Review of the facility's policy titled Nurse Staff Posting Information, dated 03/06/25, indicated, . The Nurse Staffing Sheet will be posted on a daily basis . NJAC 8:39-41.2