STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Westfield, LLC	1515 Lamberts Mill Road Westfield, NJ 07090

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Complaint #: NJ00182358, NJ00169293 Based on interview, record review, and policy review, the facility failed to provide evidence that two of two residents (Resident (R) 5 and R30) reviewed for room transfers in a total sample of 34 residents were notified of the reason in writing for the transfer and when the transfer would occur prior to being transferred to another room in the facility. This failure had the potential to impact the emotional well-being of the residents facing the challenge of a new roommate. Findings include: 1. Review of R5's electronic medical record (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R5's EMR titled admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/23 indicated the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which revealed the resident was moderately cognitively impaired. Review of a document provided by the facility titled Census List for R5 indicated R5 was admitted to R30's room on 10/30/23. 11/25/23. The document dated 11/15/23 revealed the resident was transferred to a new room at 7:59 PM. There was no evidence that R5 was provided with written notice that he/she was to move rooms on 11/15/23. 2. Review of R30's EMR titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R30's EMR titled admission MDS with an ARD of 10/26/23 indicated the resident had a BIMS score of 14 out of 15 revealed the resident was cognitively intact. There was no evidence in the medical record that R30 was provided with written notice that R5 was going to be moved into R30's room on 10/30/23. (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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/22/25 at 10:37 AM, the Social Services Director (SSD) confirmed she could not locate a written room transfer notice for R5 or R30. The SSD stated she has been in her position for the past year and currently the facility would discuss potential roommate changes and compatibility. The SSD stated she then documented in the clinical record the change and provide the resident with a written transfer notice. During an interview on 01/23/25 at 3:03 PM, when asked about the facility's process for resident/family notification of a room change notification, the Regional Clinical Nurse stated she was not aware of what the facility policy was at the time of R5's room transfer in 2023 and when the facility moved R30 into R5's room. Review of a facility policy titled Change of Room or Roommate dated 11/13/24 indicated . It is the policy of this facility to conduct changes to room and/or roommate assignments when considered necessary and/or when requested by the resident or resident representative . Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible . The notice of a change in room or roommate will be provided in a language and manner the resident and representative understands and/or requests and will include the reason(s) why the move or change is required . N.J.A.C. 8:39-4.1(a)(13)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Complaint #'s: NJ00167278, NJ0161406 Based on observation, interview, and review of the facility policy, the facility failed to provide proper tracheostomy care that included cleaning the skin around the stoma and cleaning the outer cannula and flange [neck plate] in accordance with professional standards for three of seven residents (Resident (R) 23, R33, and R34) reviewed for care. This failure could lead to stoma and lungs infections. Findings include: 1. Review of R23's Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed R23's diagnoses included anoxic brain damage, respiratory failure, and speech and language deficits following cerebrovascular disease. Review of R23's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/21/24, located in the EMR MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of zero out of 15 which indicated the resident had severely impaired cognition. Review of R23's Orders dated 09/09/24, located in the Orders tab of the EMR, revealed Tracheostomy care every shift and as needed. During an observation in R23's room on 01/22/25 at 11:30 AM, Registered Nurse (RN) 3 performed tracheostomy care. During the procedure, RN3 removed and discarded the soiled split gauze from the stoma under the flange. RN3 changed gloves and applied new split gauze to stoma under the flange. RN3 did not clean the skin around the stoma, outer cannula, or flange. 2. Review of 33's Admission Record in the Profile tab of the EMR revealed an admitted [DATE]. The Admission Record revealed R33's diagnoses included chronic respiratory failure with hypoxia and dysphagia following other cerebrovascular disease. Review of R33's admission MDS with an ARD of 01/08/25, located in the MDS tab, revealed a BIMS score of zero out of 15 which indicated the resident had severely impaired cognition. Review of R33's Orders dated 01/01/25 in the Orders tab of the EMR, revealed Tracheostomy care every day and evening shift and as needed. During an observation in R33's room on 01/22/25 at 7:24 AM, RN3 performed tracheostomy care. During the procedure, RN3 removed and discarded the soiled split gauze from stoma under the flange. RN3 changed gloves and applied new split gauze to stoma under the flange. RN3 did not clean the skin around the stoma, outer cannula, or flange. 3. Review of R34's Admission Record in the Profile tab of the EMR revealed an admitted [DATE]. The Admission Record revealed R34's diagnoses included myasthenia gravis with acute exacerbation, cerebral palsy, and chronic respiratory failure with hypoxia. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R34's quarterly MDS with an ARD of 12/20/24, located in the MDS tab, revealed a BIMS score of ten out of 15 which indicated the resident had moderately impaired cognition. Review of R34's Orders dated 09/09/24 in the Orders tab of the EMR revealed Tracheostomy care every day and night shift and as needed. During an observation in R34's room on 01/22/25 at 7:41 AM, Licensed Practical Nurse (LPN) 4 performed tracheostomy care. During the procedure, LPN4 removed and discarded the soiled split gauze from stoma under the flange. LPN4 changed gloves and applied new split gauze to the stoma under the flange. LPN4 did not clean the skin around the stoma, outer cannula, or flange. During an observation in R34's room on 01/22/25 at 1:10 PM, LPN4 performed tracheostomy care again per R34's request. During the procedure, LPN4 removed and discarded the soiled split gauze from stoma under the flange. LPN4 changed gloves and applied new split gauze to the stoma under the flange. LPN4 did not clean the skin around the stoma, outer cannula, or flange. During an interview on 01/22/25 at 11:35 AM, RN3 stated, Yes I should have cleaned around the stoma to help prevent infection. During an interview on 01/22/25 at 1:20 PM, LPN4 stated, I didn't clean around the stoma and should have. During an interview on 01/22/25 at 8:51 AM, RN2, the unit manager for the tracheostomy [trach] unit, stated, During trach care, we have to clean every part of the trach and around the stoma even if it is a disposable cannula to prevent infection. During an interview on 01/22/25 at 9:02 AM, the Assistant Director of Nursing (ADON) stated, I do training on trach care with new hires and all staff during annuals, if there is an incident, if they need help, but at least once or twice a year. I train them when you take the dirty gauze off then you clean everything before you put new gauze on. During an interview on 01/22/25 at 9:25 AM, the Director of Nursing (DON) stated, We train them when you remove the dirty, you clean around the stoma before you put the new on. It should be second nature that cleaning is done without even having to think about. Review of the facility's policy titled, Ventilator Unit Policy and Procedures: Tracheostomy Care, undated, indicated under the section Policy: Tracheostomy care is performed by the nurse every shift and when needed. Maintain a secure artificial airway and integrity of the skin at the stoma and neck. Indicated under the section Procedure: 14. Clean area around stoma using normal saline or prescribed medication with sterile cotton tip applicators, if needed. Always wipe away from the stoma' utilizing a clean applicator with each wipe. 15. Clean the remainder of the neck with a cotton tip applicator or a 4x4 drain sponge. 16. Dry well with a 4x4 drain sponge. 17. Apply drain sponge under flanges of tracheostomy. N.J.A.C. 8:39-27.1(a)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Complaint #: NJ00169314 Based on observation, interview, and review of the facility policy, the facility failed to identify and manage pain for one of 34 residents (Resident (R) 34) reviewed for pain. This failure could lead to reduced quality of life, depression and anxiety, and sleep disturbances. Findings include: Review of R34's Admission Record in the Profile tab of the electronic medical record (EMR) revealed an admitted [DATE]. The Admission Record revealed R34's diagnoses include myasthenia gravis with acute exacerbation (chronic autoimmune disease that causes muscle weakness), cerebral palsy (group of disorders that affect a person's ability to move, balance, and maintain posture), and chronic respiratory failure with hypoxia. Review of R34's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/20/24, located in the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of ten out of 15 which indicated the resident had moderately impaired cognition. Review of R34's Orders dated 12/27/24 in the Orders tab of the EMR, revealed Acetaminophen [pain reliever] oral tablet 500 mg [milligrams], give two tablets via G-tube [gastronomy tube] every six hours as needed for pain. During an observation in R34's room on 01/22/25 at 7:45 AM, Licensed Practical Nurse (LPN) 4 was performing tracheostomy care. R34 was shaking his/her right hand and pointing to his/her groin area. LPN4 asked, You have to urinate? You urinate through your tube. R34 repeated the movement. LPN4 stated, You have a tube you urinate through that goes to a bag. R34 repeated the same movement. LPN4 stated, You have a tube that goes to your bladder that you urinate through that empty into a bag. This surveyor asked LPN4 if R34 could write on a notebook to communicate and LPN4 gave R34 a notebook from the bedside table. R34 wrote pain in the notebook. LPN4 asked, Where is your pain? Is it all over? LPN4 did not allow R34 time to respond. LPN4 asked, Do you want some Acetaminophen? R34 shrugged his/her shoulders. LPN4 let R34 know she would see what was ordered and bring something for pain. LPN4 returned to give Acetaminophen. During an interview in R34's room on 01/22/25 at 8:15 AM, when asked how frequently he/she had pain, R34 wrote, Everyday. R34 was asked to write down where pain was. R34 wrote, When I urinate. R34 was asked how long has pain been going on. R34 wrote, Two weeks. When asked if the Nurses assessed pain every day; R34 shook his/her head no. During an interview on 01/22/25 at 8:47 AM, LPN4 stated, This is the first time that R34 has ever verbalized or expressed having pain to me. I would watch facial expressions and non-verbal cues, or residents will also tell me if they have pain. Pain monitoring is completed every shift. A box automatically pops up in the EMR asking us if resident has pain and we must answer for every resident. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/22/25 at 8:51 AM, RN3, unit manager for tracheostomy unit, stated, I expect my Nurses to do the same as I would to monitor and manage pain. We ask the resident and use numerical, or whichever pain scale is appropriate for non-verbal residents. We watch non-verbal indicators and facial expressions as well. We assess the location of pain, palpate and watch for non-verbal indicators, watch their movement as to what is aggravating the pain. We take their pain as whatever the resident states it is. There is a protocol we follow to address and monitor pain. If their current pain management order isn't effective, then we notify the NP [Nurse Practitioner] or doctor and get new orders or direction. If it's a new pain, then it should be put in [EMR] as a change of condition. I will see it on the report and then we can care plan it appropriately. During an interview on 01/22/25 at 9:25 AM, the Director of Nursing (DON) stated, With our residents that can't verbalize like [R34], I expect my Nurses to still communicate with them to learn about their pain. If they are slow with their response, then we must have more patience to find out what their pain is. We have to allow them time to communicate in their own way to figure out specifics of their pain and what is going on with them. Review of the facility's policy titled, Pain Management, dated 09/01/24, indicated under the section, Policy: The facility must ensure that pain management is provided to residents who require such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Indicated under the section, Recognition: 1.a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated. Indicated under the section, Pain Assessment: 2.e. Identifying key characteristics of the pain: i. Duration of pain ii. Frequency iii. Location iv. Timing v. Pattern (constant or intermittent) vi. Radiation of pain. 2f. Obtaining descriptors of the pain (e.g. stabbing, aching, pressure, spasms). 2g. Identifying activities, resident care of treatment that precipitate or exacerbate pain. N.J.A.C. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Complaint #: NJ00172868 Based on observations, record review, interview, and facility policy review, the facility failed to ensure one out of three residents (Resident (R) 17) reviewed for side rails had interventions attempted prior to the implementation of side rails. This failure created the potential for the resident to be injured related to potentially unnecessary side rails installed and in use on her bed. Findings include: Review of R17's electronic medical records (EMR) titled Admission Record located under the Profile tab indicated the resident was admitted to the facility on [DATE]. Review of R17's EMR titled Consent for the Use of Side Rails located under the Misc Miscellaneous) tab dated 08/14/24. The risks and benefits for the use of side rails were discussed at this time with the resident's representative. Review of R17's EMR titled Care Plan located under the Care Plan tab dated 08/18/24 indicated the resident used side rails for safety during the provision of care to assist with bed mobility. Review of R17's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/26/24 indicated the resident had a Brief Interview of Mental Status (BIMS) score of three out of 15 which revealed the resident was severely cognitively impaired. The assessment indicated R17 required substantial/maximum assistance from staff to roll from lying on back to left and right side and return to lying on back on the bed. Review of R17's EMR titled Side Rail assessment dated [DATE] indicated the resident was able to use the side rails to move from one side to another. An observation was conducted on 01/21/25 at 10:09 AM, R17 was sitting in his/her wheelchair. During an interview at this time, Certified Nurse Aide (CNA) 1stated R17 would grab the siderails during the provision of cares while the resident was in bed. During an interview on 01/22/25 at 6:57 AM, Licensed Practical Nurse (LPN) 1 confirmed R17 will use the side rails when staff were providing his/her care while in bed. During an interview on 01/22/25 at 10:16 AM, the Director of Rehabilitation (DOR) stated therapy did not determine the use of side rails on a resident's bed. The DOR stated this was a nursing decision and typically, the side rails were already on a resident's bed before therapy decides on other positioning devices, such as a wedge or bolster. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/23/25 at 3:03 PM, the Director of Nursing (DON), Assistant Administrator, a former Administrator, and Regional Clinical Nurse, were all asked what prior interventions were implemented and failed prior to the use of R17's side rails. No additional information was provided on prior interventions by the end of the survey. Review of a facility policy titled Proper Use of Side Rails dated October 2019 indicated . The purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids and to prohibit the use of side rails as restraints unless necessary to treat a resident's medical symptoms . Less restrictive interventions that will be incorporated in care planning include . Providing restorative care to enhance abilities to stand safely and to walk . Providing a trapeze to increase bed mobility . Placing the bed lower to the floor and surrounding the bed with a soft mat . Documentation will indicate if less restrictive approaches are not successful, prior to considering the use of side rails . N.J.A.C. 8:39-11.1