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	03/10/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34033 COMPLAINT# NJ00174720 Based on observations, interviews, record review, and review of facility documentation, it was determined that the facility failed to submit a report to the New Jersey Department of Health (NJDOH) within the two-hour timeframe for an allegation of abuse against Certified Nursing Assistants (CNA) for two (2) of two (2) residents (Resident #61 and #241) reviewed for abuse reporting. The deficient practice was evidenced by the following: 1. On 2/28/25 at 11:00 AM, the surveyor observed Resident #61, in the dementia care activity room, seated in a wheelchair at a table with tablemates, flipping through a magazine. The resident said hello and smiled at the surveyor. On 3/3/24 at 12:50 PM, the surveyor observed Resident #61, in the dining room, awaiting lunch. The surveyor attempted to interview the resident, but the resident was unable to answer questions. The surveyor reviewed the electronic medical record (EMR) for Resident #61. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but not limited to; unspecified dementia, unspecified severity, with other behavioral disturbance (a mental disorder that can cause a person to lose the ability to learn, remember, think, solve problems, and make decisions). A review of the quarterly Minimum Data Set (MDS), an assessment tool dated 12/22/24 revealed the resident had a Brief Interview for Mental Status (BIMS) of 00 out of 15, indicating the resident's cognition was severely impaired. A review of the individual comprehensive care plan (ICCP) revealed a focus of has a mood and behavior problem in r/t (related to) resistive to care-refusing care, hitting staff, yelling/screaming, scratching staff, kicking, refusing medication, insomnia (difficulty sleeping) secondary to dementia with behavior problem and HOH (hard of hearing), Revision on 6/14/2024 and an Intervention of Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 10/23/2023. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Reportable Event Record/Report provided by the Licensed Nursing Home Administrator (LNHA #1) dated 12/19/23, revealed it was completed by a previous LNHA, LNHA #2, which indicated Licensed Practical Nurse (LPN #1) alleged that CNA#1 yelled at Resident #61. In addition, the report indicated that the incident occurred on12/19/23 at 8:42 AM and was called in to the NJDOH by LNHA #2 on 12/20/23 at 6 PM. A review of a comprehensive MDS dated [DATE], the MDS which was nearest the date of the allegation, reflected that the resident had a brief interview of mental status (BIMS) score of one (1) out of 15, indicating the resident had severely impaired cognition. On 3/4/25 at 10:47 AM, the surveyor interviewed LPN#1, who verified that she had completed a written statement on 12/19/23. LPN#1 also verified that she had made an accusation of abuse regarding CNA#1 and Resident #61, on the morning of 12/19/23. On 3/4/25 at 11:33 AM, the surveyor interviewed LNHA #2, who verified that she had completed the Reportable Event Record/Report and was the LNHA, at that time. LNHA #2 also verified that the allegation of abuse occurred on 12/19/23 at 8:42 AM and that the NJDOH was notified of the allegation on 12/20/23 at 6 PM. LNHA #2 stated that she did not recall why there was a delay in reporting the allegation and thought that maybe she was trying to get all the information first. LNHA #2 acknowledged this was an allegation of abuse and should have been reported immediately. 41858 2. On 2/28/25 at 11:41 AM, during initial tour, the surveyor observed Resident #241 in bed, dressed, lying on a mechanical lift pad. The resident stated they were waiting to go to therapy, which was usually around lunch time. The surveyor reviewed the EMR for Resident # 241. A review of the Admission Record revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified fracture of lower end of left femur (thigh bone, near the knee), subsequent encounter for closed fracture with routing healing, multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing, and unspecified fracture of sacrum (back of the pelvic bone), subsequent encounter for fracture with routine healing. A review of the comprehensive MDS, dated [DATE], revealed the resident had a BIMS of 15 out of 15, indicating the resident was cognitively intact. A review of the ICCP revealed a focus of an ADL (activities of daily living) self-care performance deficit r/t Activity Intolerance, Limited Mobility, Date Initiated: 02/12/2025. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 8:30 AM, during incontinence rounds with the Assistant Director of Nursing (ADON) and the surveyor, Resident # 241 was in bed and agreed to be checked, no concerns. At that time in the presence of the ADON, who was standing on the side of the resident's bed, and the surveyor, who was standing at the bottom of the resident's bed, the resident stated, I try not to complain but after therapy yesterday I was brought back to the room and was asked to stay in the chair until after lunch. The resident agreed. Resident #241 stated they fell asleep in the chair and when they woke up, they were all crooked. The resident stated they hit the buzzer (call bell) and around 2:45 (PM) a very nice CNA came in and said it was shift change and someone would be in soon. I hit my buzzer again and someone came in and I said I wanted to get back in bed. That person turned off the light. The resident further stated, then around 5:00 (PM), 2 aides came in, a male and a female, they were complaining to each other about their work, and then they yelled at me saying I never hit my call light. The surveyor asked the resident again about the event that happened the day before with the 2 CNAs, the resident stated again they yelled at me. The surveyor asked the ADON to provide her with any follow up that was done for the resident regarding the this event. On 3/4/25 at 8:45 AM, the surveyor interviewed CNA #2, who stated she was the assigned CNA for Resident #241. She stated if a resident told her that they were yelled out, she would tell the nurse, and the nurse would come and talk to the resident. She added, I am not sure if I would have to give a statement. On 3/4/25 at 8:48 AM, the surveyor interviewed CNA #3, who stated if a resident stated they were yelled out, I would get the nurse right away. On 3/4/25 at 12:48 PM, the surveyor followed up with the Director of Nursing (DON) regarding the event that occurred the day before with Resident #241. He stated he was aware of the incident Resident #241 had with a CNA and he would follow up with ADON. On 3/04/25 at 1:19 PM, the DON informed the surveyor, the ADON had left message with the agency because the CNA was an agency CNA. The surveyor requested to be provided with what was done so far for the investigation. On 3/05/25 at 10:24 AM, the surveyor asked the DON for the investigaiton for Resident # 241. The DON stated because it was a complaint we (the facility) did a grievance. He added they were conducting an investigation because they (the male and female CNAs) were both from an agency so they (the facility) called the agency. The DON stated they (the male and female CNAs) were DNR'd, meaning they cannot come back to the facility, and we (the facility) are waiting for a response from the agency. On 3/05/25 at 10:40 AM, the DON provided the surveyor with the investigation. A review of the investigation, at that time, did not reveal a statement from the ADON. The surveyor asked the DON who should be interviewed, he stated they (the facility) should interview anybody who heard or seen anything, anybody who could have been a witness. The surveyor asked where the ADONs statement was, he stated it should be there. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/05/25 at 12:17 PM, the DON provide the surveyor with the ADON's typed statement. At that time, a review of the statement revealed On 3/4/25 during incontinence rounds, [Identifier redacted] reported that [Identifier redacted] was not put back to bed until 5 pm on 3/3/25. [Identifier redacted] also mentioned that the 2 CNAs that were helping [Identifier redacted] are arguing. They're not arguing with [Identifier redacted] but they're arguing with each other. It was signed by the ADON. The surveyor, in the presence of the survey team, made the DON aware that during the incontinence rounds, Resident #241 had stated they (the male and the female CNA) yelled at me saying I never hit my call light. He stated he was unaware of that statement and would have to review this further. Further review of the investigation revealed a statement provided by the Regional Clinical Supervisor (RCS) who interviewed the resident. The statement did not mention the CNA's yelling at the resident, it addressed heel boots and CNAs arguing, a male and a female. On 3/05/25 at approximately 12:30 PM, the RCS interviewed the surveyor in the presence of the DON, the LNHA, and the ADON, regarding Resident #241 stating they (the male and the female CNA) yelled at me saying I never hit my call light. The surveyor reviewed the above mentioned interview that occurred during the incontinence rounds on 3/4/25 at 8:30 AM with the ADON. The ADON denied hearing the resident's statement of being yelled out. The surveyor could not explain why the ADON was not listening to the resident at that time. The RCS stated, this statement changes the investigation. The DON provided the surveyor with an email from the DON, to the NJDOH dated 3/5/25 at 1:27 PM, reporting the 3/4/25 event. On 3/6/25 at 12:55 PM, during a meeting with the survey team, the LNHA, the DON, the Regional Director of Operations and the RCS were made aware of the above concerns for Resident #61 and #241. On 3/7/25 at 10:05 AM, in the presence of the survey team, the LNHA stated he was the abuse officer. He stated an allegation of abuse should be reported immediately to DOH, within 2 hours. He added staff would be suspended right away, an investigation would be started, they would speak to the resident and all staff assigned that day including supervisors. He stated, A summary and conclusion should be done, depending on the outcome we would proceed from there. A review of the facility policy for Incident/Accident Investigating and Reporting with a date implemented 9/1/2024 provided by the LNHA reflected for Reporting/Response The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made., if the events that cause the allegation involve abuse or result in serious bodily injury, or NJAC 8:39-4.1(a)(5), 9.4(f)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41858 Based on observations, interviews, record review and review of other facility documentation, it was determined that the facility failed to ensure heel booties were consistently applied to prevent skin breakdown. This deficient practice was identified for 1 of 4 residents (Resident #241) reviewed for position and mobility. This deficient practice was evidenced by the following: On 2/28/25 at 11:41 AM, during initial tour, the surveyor observed Resident #241 in bed dressed, lying on a mechanical lift pad. The resident was wearing socks. The resident stated they were waiting to go to therapy, which was usually around lunch time The surveyor reviewed the electronic medical record (EMR) for Resident # 241. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified fracture of lower end of left femur (thigh bone, near the knee), subsequent encounter for closed fracture with routing healing, multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing, and unspecified fracture of sacrum (back of the pelvic bone), subsequent encounter for fracture with routine healing. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 2/18/25, revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. Further review revealed the resident had lower extremity impairment on one side and was receiving physical and occupational therapy. A review of the individual comprehensive care plan (ICCP) revealed a focus of has potential/actual impairment to skin integrity r/t fragile skin, incontinence, limited mobility, revision on 2/12/25, and interventions of Bilateral heel boots on when in bed, may remove during care, dated initiated 2/12/25. A review of physician orders revealed a physician's order (PO) for Bilateral heel boots on when in bed, may remove during care, every shift for offloading, Active 2/12/2025. A review of the February 2025 and March 2025 Treatment Administration Records (TARs) revealed Bilateral heel boots on when in bed, may remove during care, every shift for offloading, -Order Date 02/12/2025 1424 (2:24PM) with a check starting with the Eve (evening) on 2/12/25 and continued for Day, Eve and Nigh (night) for every day including all shifts for 3/4/25. A review of the chart codes revealed a check=Administered. Further review revealed an optional code of 2=Drug refused, which was not used. A review of the physician progress notes revealed on 02/14/205 at 16:25, 2/18/25 at 16:11, 2/21/25 13:05, 02/25/2025 at16:36 (4:36 PM), 2/28/25 15:50, and 3/4/25 at 16:16 A General Note .Plan: .4. Skin: keep heels off bed. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/25 at 8:30 AM, during incontinence rounds with the Assistant Director of Nursing (ADON) and the surveyor, Resident # 241 was in bed and agreed to be checked, no concerns. The surveyor asked the ADON to pick up the blankets from the resident's feet. The surveyor observed the resident wearing blue nonskid socks with their feet resting directly on the bed. The surveyor asked the resident if they wore heel booties on their feet and they stated, No I do not, I only wear socks. On 3/4/25 at 8:45 AM, the surveyor interviewed Certified Nursing Assistant (CNA) #1, who stated she was the assigned CNA for the resident. She stated the resident had cushions on each side of them while in bed, wore a leg brace and booties (heel booties). The surveyor asked the CNA to go to the room and show the surveyor. CNA #1 showed the surveyor the cushions and the brace that was on the residents left leg. She confirmed at that time the resident was not wearing booties. Once CNA #1 and the surveyor exited the room, CNA #1 stated the surveyor misunderstood her, the resident did not have booties. She stated therapy lets them (the staff) know what devices the residents need and she finds out in report. She added she knows the resident well and knows what the resident needs. On 3/4/25 at 8:52 AM, the Regional Clinical Supervisor (RCS) approached the surveyor and stated the heel booties were in the room for Resident #241 and now the resident was refusing them. On 3/4/25 at 12:48 PM, the surveyor interviewed the Director of Nursing (DON), who stated he was aware of the above incident with the heel booties for Resident #241. The surveyor asked what a PO for heel booties while in bed, may remove during care meant, he stated heel booties should be on, if not it should be documented why they weren't such as resident refused. He added if they continued to refuse the heel booties, the doctor should be called and wound care should be made aware. On 3/5/2025, the surveyor reviewed the progress notes from admission to present, which did not reveal a note that the resident refused the heel booties. On 3/06/25 at 12:55 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator, the DON, the Regional Director of Operations and the RCS were made aware of the above concerns. A review of the untitled facility policy, updated 10/2021, revealed Policy: Splints/ adaptive devices are to be applied as ordered by physiatrist/attending physician/nurse practitioner. A review of the facility's policy, Support Surface Guidelines updated 10/2019, revealed Purpose: The purpose of this procedure is to provide guidelines for the assessment of appropriate pressure reducing and relieving devises for residents at risk of skin breakdown. General Guidelines: 1. Redistributing support surfaces are to promote comfort for all bed- or chair bound residents, prevents skin breakdown, promote circulation and provide pressure relief or reduction .4. Elements of support surfaces that are critical to pressure ulcer preventions and general safety include pressure redistribution NJAC 8:39-27.1 (a)(e)

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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. 41858 Based on interviews, record review, and review of other pertinent facility documentation, it was determined that the facility failed to meet the professional standards of practice by not appropriately assessing, monitoring, and documenting PRN (as needed) pain medications. This deficient practice was identified for 1 of 1 resident (Resident #241) reviewed for pain management. This deficient practice was evidence by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey states; The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. 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. On 2/28/25 at 11:41 AM, during initial tour, the surveyor observed Resident #241 in bed dressed, lying on a mechanical lift pad. The resident was wearing socks. The resident stated they had their pain medicine and was waiting to go to therapy, which was usually around lunch time. The surveyor reviewed the electronic medical record (EMR) for Resident # 241. A review of the Admission Record (an admission summary) revealed the resident was admitted to the facility with diagnoses which included but were not limited to; unspecified fracture of lower end of left femur (thigh bone, near the knee), subsequent encounter for closed fracture with routing healing, multiple fractures of ribs, left side, subsequent encounter for fracture with routine healing, and unspecified fracture of sacrum (back of the pelvic bone), subsequent encounter for fracture with routine healing. A review of the comprehensive Minimum Data Set (MDS), an assessment tool, dated 2/18/25, revealed the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, indicating the resident was cognitively intact. Further review, revealed the resident had lower extremity impairment on one side, was receiving physical and occupational therapy and receiving pain medicine. A review of the individual comprehensive care plan (ICCP) revealed a focus of has potential for pain r/t (related to) Chronic Pain, Date Initiated: 02/12/2025 and an intervention of evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition, Date Initiated: 02/12/2025. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of physician orders revealed a physician's order (PO) for the following: - traMADol HCl Oral Tablet 50 MG (Tramadol HCl), 1 tablet by mouth every 4 hours as needed for moderate to severe pain, active 3/2/25, D/C (discontinue) date 3/4/25. -traMADol HCl Oral Tablet 25 MG (Tramadol HCl), Give 25 mg by mouth every 8 hours as needed for moderate to severe pain for 7 Days, Active 2/26/2025, 15:30 (3:30 PM), D/C Date 3/2/25. -traMADol HCl Oral Tablet 50 MG (Tramadol HCl), 1 tablet by mouth every 8 hours as needed for severe pain for 10 Days, Active 2/13/2025, 14:26 (2:26 PM). -Acetaminophen Tablet 325 MG, Give 2 tablet by mouth every 4 hours as needed for Mild Pain Do not exceed 3,000mg in 24 hrs, Active, 2/28/2025, 16:00 (4:00PM). -Pain flow sheet **Document with each PRN pain medication administration Characteristics 20=Aching 21=Burning 22=Crampy 23=Numbness 24=Pins/needles 25=Sharp 26=Stabbing 27=Throbbing 30=Other Frequency- 40=Rarely 41=Occasionally 42=Frequently 43=Almost constantly 44=Unable to answer Non-Med Intervention- 0=Heat 1=Cold 2=Position 3=Massage 4=Meditation 5=Music 6= Gentle ROM 7=TENS 8= Support group 10=Other, as needed **When addressing follow up address any side effects**, Active, 2/11/2025 17:33. (5:33PM). A review of the February 2025 Medication Administration Record (MAR) revealed the resident received Acetaminophen Tablet 325 MG, Give 2 tablet by mouth every 4 hours as needed for Mild Pain on 2/13, 2/15, 2/24, 2/26 and 2/27;traMADol HCl Oral Tablet 50 MG (Tramadol HCl), Give 25 mg by mouth every 8 hours as needed for severe pain was given twice each day on 2/14, 2/15, 2/18,and 2/19; once a day on 2/16, 2/17, 2/20, 2/21, 2/22, and 2/24; and traMADol HCl Oral Tablet 25 MG (Tramadol HCl), Give 25 mg by mouth every 8 hours as needed for moderate to severe pain was given once a day on 2/26; twice a day 2/27 and 2/28. A further review of the February 2025 MARs revealed Pain flow sheet **Document with each PRN pain medication administration Characteristics 20=Aching 21=Burning 22=Crampy 23=Numbness 24=Pins/needles 25=Sharp 26=Stabbing 27=Throbbing 30=Other Frequency- 40=Rarely 41=Occasionally 42=Frequently 43=Almost constantly 44=Unable to answer Non-Med Intervention- 0=Heat 1=Cold 2=Position 3=Massage 4=Meditation 5=Music 6= Gentle ROM 7=TENS 8= Support group 10=Other, as needed **When addressing follow up address any side effects**, Active, 2/11/2025 17:33. (5:33PM) was left blank (not documented as completed) from 2/11 to 2/28/25. A review of the March 2025 MARs revealed the resident received Acetaminophen Tablet 325 MG, Give 2 tablet by mouth every 4 hours as needed for Mild Pain on 3/1; traMADol HCl Oral Tablet 25 MG (Tramadol HCl), Give 25 mg by mouth every 8 hours as needed for moderate to severe pain was given three times on 3/1; traMADol HCl Oral Tablet 50 MG (Tramadol HCl), 1 tablet by mouth every 4 hours as needed was given on once a day on 3/2 and 3/3. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A further review of the March 2025 MARs revealed Pain flow sheet **Document with each PRN pain medication administration Characteristics 20=Aching 21=Burning 22=Crampy 23=Numbness 24=Pins/needles 25=Sharp 26=Stabbing 27=Throbbing 30=Other Frequency- 40=Rarely 41=Occasionally 42=Frequently 43=Almost constantly 44=Unable to answer Non-Med Intervention- 0=Heat 1=Cold 2=Position 3=Massage 4=Meditation 5=Music 6= Gentle ROM 7=TENS 8= Support group 10=Other, as needed **When addressing follow up address any side effects**, Active, 2/11/2025 17:33. (5:33PM) was left blank (not documented as completed) from 3/1 to 3/4/25. On 3/5/25 at 11:36 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #1, who stated she was Resident #241's assigned nurse. She acknowledged Resident #241 received PRN pain medication. The surveyor reviewed the above PO for Pain flow sheet **Document with each PRN pain medication administration. She stated she had no idea what it was, I assume it should be document with prn pain medicine. On 3/6/25 at 10:45 AM, the DON reviewed MARs with the PO Pain flow sheet **Document with each PRN pain medication administration PRN pain documentation in the presence of the surveyor. He stated it was to explain in more detail the type of pain the resident was experiencing. The surveyor asked when it should be documented on, the DON stated, according to this, whenever we give a PRN pain medication. He added if it was in the system, yes the nurses should be aware and document accordingly. On 3/06/25 at 12:55 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator, the DON, the Regional Director of Operations and the Regional Clinical Supervisor were made aware of the above concerns. A review of the facility's policy, Pain Management date implemented 9/1/22024 revealed 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 residents' goals and preferences .Pain Assessment: 1. The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. 2. Based on professional standards of practice .e. Identifying key characteristics of the pain: v. pattern (e.g. constant or intermittent; f. obtaining descriptors of pain (e/g/ stabbing, aching, pressure, spasms. NJAC 8:39-27.1 (a)

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	315122	A. Building B. Wing	03/10/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 40042 Complaint # NJ166824 Based on observation, interviews, and review of pertinent facility documents, it was determined that the facility failed to ensure the safe and appetizing temperatures of hot foods served to the residents. This deficient practice was identified for 1 of 35 residents (Resident #14) interviewed during the initial pool process and confirmed during the lunchtime meal service on 3/6/25 on 1 of 5 nursing units tested for food temperatures by the surveyor and witnessed by the Director of Nursing. The deficient practice was evidenced by the following: On 2/28/25 at 12:13 PM, the surveyor observed Resident #14 in their room. At that time, the resident stated that the food was cold. The surveyor reviewed the electronic medical record (EMR) for Resident #14. A review of the Admission Record (an admission summary), reflected the resident had diagnoses that included but were not limited to; bipolar disorder (associated with episodes of mood swings ranging from depressive lows to manic highs), gastro-esophageal reflux disease (a disease in which stomach acid or bile irritates the food pipe lining), anxiety disorder (intense fear of everyday situations) and obesity (having to much body fat) due to excess calories. A review of a quarterly Minimum Data Set (MDS), a tool to facilitate the management of care dated 11/26/24, reflected the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15, which indicated the resident's cognition was intact. A review of the Order Summary Report reflected a Physician's Order dated 3/7/24 for a No Added Salt Regular consistency diet. On 3/6/25 at 11:24 AM, the surveyor calibrated a state issued digital thermometer to 32 degrees Fahrenheit (F), via the ice bath method [An effective way to gauge the accuracy of your thermometer. This simple experiment compares the temperature of your thermometer to ensure it is reading to the freezing point of water (32.0 F)], in the presence of the survey team. On 3/6/25 at 11:44 AM, the first lunch food truck arrived on the [NAME] Unit. The Assistant Director of Nursing (ADON) randomly marked a regular consistency tray to be a test tray and immediately called for a replacement tray for that resident, at the request of the surveyor. The last tray was delivered at 12:02 PM. The surveyor immediately conducted food temperature checks for the test tray in the presence of the DON. The DON confirmed the following food temperature observations: Italian sausage: 116 degrees F Sauteed spinach with garlic: 127 degrees F Parmesan noodles: 123.5 degrees F (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no beverages on the tray. On 3/6/25 at 12:16 AM, the surveyor interviewed the Food Service District Manager (FSDM) in the presence of the Assistant Food Service Director (AFSD). The AFSD provided the surveyor with the completed lunch meal food temperature log (the temperatures recorded were all in safe range). The FSDM stated that residents should receive hot food at or above 140 degrees F and cold food at or below 40 degrees F for palatability. The surveyor reviewed the temperature results from the test tray, and both acknowledged the temperatures were not adequate. At that time, both stated the department conducted test tray audits and would provide copies to the surveyor. The AFSD stated that he was responsible to oversee food temperatures and that they were maintained at safe and proper temperatures. A review of the Resident Tray Assessment Report's, reflected a scoring system whereby when temperatures were taken on the nursing unit, if hot soups and beverages were less than 140 degrees F, this would result in a score of zero (indicated unacceptable), if hot entrees were 125-129 degrees F, this would result in a score of two (indicated acceptable); if hot entrees were 120-124 degrees F, this would result in a score of one (indicated needs improvement); and if a hot entree was less than 120 degrees F, this would result in a score of zero (indicated unacceptable). A review of the policy Food: Quality and Palatability dated 2/2023, from the [name redacted] contracted food service company. The policy statement reflected, Food will be palatable, attractive and served at a safe and appetizing temperature . to meet resident's needs. NJAC 8:39-17.4 (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** 48964 Based on observations, interviews, and record review, it was determined that the facility failed to ensure that staff wear the appropriate personal protective equipment (PPE) for residents on Enhanced Barrier Precautions (EBP)(designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes) to address the risk for infection transmission, in accordance with the facility policy and acceptable standards of infection control practice. This was observed for 1 of 3 unsampled residents (Resident #95) reviewed for EBP on 1 of 2 units ([NAME] Unit) and was evidenced by the following: On 3/04/25 at 08:10 AM, during incontinence rounds with the Unit Manager (UM) on the [NAME] Unit, the surveyor observed the UM approach unsampled Resident #95, who was lying in bed. The UM donned (put on) gloves and asked permission to check the resident's brief; the resident granted permission. The UM opened Resident #95's brief, pulled down the front of the brief, and allowed the surveyor to observe that the brief was wet, but not saturated and the linens were dry. After the surveyor's observation, the UM pulled up the front of the brief, refastened the brief, and pulled the linens up. The UM then removed her gloves and performed hand hygiene. On the way out of the room, the surveyor observed an EBP sign which indicated gloves and a gown were required for High-Contact Resident Care Activities. Examples of High-Contact Resident Care Activities listed on the sign included changing briefs or assisting with toileting. The surveyor questioned the UM about which resident the sign was referencing, and she stated that Resident #95 was on EBP. When asked about wearing a protective gown, the UM stated that she should have had a gown on (for the incontinence check). A review of the admission record reflected that Resident #95 had diagnoses that included but not limited to; Alzheimer's disease (a progress disease that destrys memory and other important mental functions) and gastrostomy tube (a feeding tube inserted through the abdomen into the stomach). A review of the interdisciplinary care plan revealed an intervention dated 11/10/23 with a focus area of Enhanced Barrier Precautions related to a feeding tube. The interventions included but not limited to; gown and gloves to be worn by staff during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Includes: dressing, . changing linens, changing briefs or assisting with toileting . On 3/05/25 at 1:56 PM, the surveyor interviewed the Infection Preventionist (IP), who stated that if a resident has a feeding tube and was on EBP, the staff would need to wear a gown and gloves to check their incontinent brief because that was direct contact with the resident. On 3/06/25 on 12:55 PM, during a meeting with the survey team, the Licensed Nursing Home Administrator, the Director of Nursing, the Regional Director of Operations and the Regional Clinical Supervisor were made aware of the above concern. A review of facility provided policy Enhanced Barrier Precautions, implemented 9/1/24 included: Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Policy Explanation and Compliance Guidelines: 3. b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room h. see table 1 for implementing contact versus enhanced barrier precautions for more information Table 1 included Has a wound or indwelling medical device, without secretions or excretions that are unable to be covered or contained and are not known to be infected or colonized with any MDRO as an indication for EBP. 4. High-contact resident care activities include: f. changing briefs or assisting with toileting NJAC 8:39-19.4(a)(2)(c)