STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315349	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Inglemoor, LLC	333 Grand Ave Englewood, NJ 07631

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48617 Complaint # NJ00180296 Based on interviews, record review, and review of pertinent facility documents on 12/03/2024, it was determined that the facility failed to ensure that a resident (Resident #1) was free from involuntary confinement when on 09/18/2024 a nurse on duty in night shift attached a hospital gown on the Resident's doorknob and looped it to the handrail in the hallway outside of Resident's room after the Resident in her/his wheelchair was brought back to her/his room from another resident's room. The deficient practice was observed in one of three residents and was evidenced as follows: A review of the facility's Reportable Event Record/Report (RER), a document submitted by the facility to the New Jersey Department of Health (NJDOH), dated 9/18/2024, completed by the facility Director of Nursing (DON), indicated that on 9/18/2024 it was reported to the administrator by another resident that the [Resident #'s name] door was closed in a way to prevent the resident from leaving her room. He [the other resident] notified the nurse and she [nurse] then opened the door. Further review of the RER included a SUMMARY AND CONCLUSION OF REPORTABLE EVENT/RECORD/REPORT that on 9/18/24 at 7:45 am [morning], a resident informed LNHA (Licensed Nursing Home Administrator) that the door to [Resident #1]'s room was closed in such a way that the resident would not be able to open it on the overnight shift. He [other resident] reports alerting the nurse and the door was then opened. The nurse assigned was suspended pending investigation. A complete body assessment of [Resident #1] was completed with no abnormal findings. A pain assessment was also completed with no abnormal findings .The nurse reported that she closed the door in a manner so as not to let the resident leave the room as she felt it would keep her safe from wandering the unit during the shift. When the other resident notified her that the door should not be closed in that way she did open the door, and the resident was asleep at that time. The RER further revealed under Conclusion: The nurse reports that there was no intent to harm the resident. She reports wanting to keep the resident safe throughout the night which is why she closed the door in a manner that would not allow her to leave the room. In-servicing done with nurse. The nurse was terminated for failure to follow facility protocols. A review of the Admission Record (AR), Resident #1 was admitted to the facility with the following diagnoses that included but not limited to: Osteoarthritis, Psychosis, Bipolar Disorder, Abnormalities of Gait and Mobility, Gastro-Esophageal Reflux Disease, and Atherosclerotic Heart Disease. (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 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #1's Minimum Data Set (MDS), an assessment tool that provides a comprehensive assessment of a resident's functional capabilities, dated 09/06/2024, indicated Resident #1's Brief Interview for Mental Status (BIMS) Score was 12 revealing Resident #1's cognition was moderately impaired. The MDS further revealed in Section GG-Functional Abilities and Goals that Resident #1 required assistance in his/her completion of Activities of Daily Living (ADLs) such personal hygiene and toileting but independent in eating and mobility while in bed and was able to propel self while in wheelchair. A review of Resident #1's Care Plan (CP), initiated on 01/30/2023 revealed under Focus [Resident #1's name] is at risk for elopement related to: has made attempts to get in elevator unescorted during her stay in facility. Under Goal [Resident #1's name] will not attempt to leave the facility without an escort. Under Interventions, it included: Monitor the nature and circumstances (1.e., triggers) of attempted elopement: during specific activities, involvement of others with resident/patient, patterned etc. and adjust care delivery . Divert [Resident's name] by giving alternative objects or activities such as snacks and jigsaw puzzles. A review of the statement document obtained by the LNHA from the nurse, Licensed Practical Nurse (LPN #1), involved in the incident from the night shift on 9/18/2024, LPN #1 in her statement informed LNHA that a resident, WD [resident's name] in [room [ROOM NUMBER]], informed the nursing staff that resident [Resident #1's name], who resides in [room [ROOM NUMBER]], was in her/his room during the previous evening. She [LPN #1] then described how the other night nurse, LPN #2 [name] went to [WD], to redirect [Resident #1's name] back to her/his room. LPN #2 informed LPN #1 of what transpired. Later that evening, LPN #1 went to check on [Resident #1] who was in her/his room and upon checking saw that Resident #1 was getting into bed. LPN #1 stated that when she left Resident #1's room she attached a night gown to the door handle and looped it into the side rail in the hallway. She then moved down the hallway and was observing the door to Resident #1's room. She [LPN #1] went back to sit back at the nurse's station. LPN #1 then stated that [WD] came to the nurse's station and informed LPN #1 that the doors should not be closed and that the door to [Resident #1]'s room should not be impeded. LPN #1 told the LNHA that she then went to open the door at [Resident #1]'s room [213]. On 12/03/2024 at 1:25 pm [afternoon], the Surveyor placed a call to LPN #1 who did not return the call. On 12/03/2024 at 11:07 am [morning], during the Surveyor's tour in Second Floor nursing unit, Resident #1 was noted in her/his room [213] and in her/his wheelchair with a Certified Nursing Assistant (CNA #1). Resident #1 was observed able to propel self in her/his wheelchair. Surveyor attempted to interview Resident #1. Resident #1 was noted confused. In the interview of the Surveyor with CNA#1, CNA stated she was a floater in this assignment. CNA#1 further stated Resident #1 was confused and could go around when she/he was in wheelchair. She stated that Resident #1 had no behaviors but at times combative during care. CNA1 stated Resident #1 wandered in while in her/his wheelchair that was why we always put her in the dayroom for activities during the day. On 12/03/2024 at 11:31 am [morning], the Surveyor observed Resident #1 in the dayroom/activity room with other residents in activities with recreation aide. Surveyor observed no residents wandering ambulatory or non-ambulatory in the hallways. (continued on next page)

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F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/2024 at 12:23 pm [afternoon], the Surveyor interviewed Resident #1's roommate (unsampled). Resident #1's roommate was alert with periods of forgetfulness. According to Resident's roommate when asked by Surveyor regarding the 09/18/24 incident, Resident's roommate stated she/he never heard of anything or knew of incident during that time. On 12/03/2024 at 1:38 pm [afternoon], during the Surveyor interview with the LNHA and DON, the LNHA stated in the investigation that he conducted and statements from other staff in that shift, staff did not know or saw what happened. He further stated that LPN #1 said she looped nightgown around the door and she knew after the fact that it was wrong. LNHA told her it was wrong and then in- serviced her. LNHA stated there was no camera in the hallways when the Surveyor asked. LNHA stated staff did body assessment on the Resident immediately and social worker talked to other residents. A review of the facility's document on Abuse, Neglect, Exploitation Policy, revised on July 2024, under Policy: It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing abd implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property .Definitions: .Involuntary Seclusion refers to separation of a resident from other residents or from his/her room or confinement to his/her room against the resident's will or the will of the resident's legal representative . A review of the facility's undated document provided by facility on Complete Care Residents Rights under FREEDOM FROM ABUSE AND RESTRAINTS: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat symptoms and not authorized by a physician or APN for a limited period of time to protect others . N.J.A.C. 8:39 4.1(a)6