STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315122	A. BUILDING _____ B. WING _____	C 10/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	**1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00151323 Census: 199 Sample Size: 4 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR	F 656		11/4/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/02/2022

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F 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Complaint # NJ00151323 Based on interview and review of Medical Records (MR) and other pertinent facility documents on 10/13/22 and 10/14/22, it was determined that the facility failed to consistently implement the care plan interventions when providing bed mobility and transfer for Resident #2 who sustained [redacted] of unknown origin on [redacted] This deficient practice was identified for 1 of 2 residents (Resident #2) reviewed for person centered comprehensive care plan and was evidenced by the following: According to the Resident's Admission Record (AR), Resident #2 was admitted to the facility on [redacted]. The Physician's Progress Notes (PN) indicated diagnoses that included but were not limited to: [redacted]	F 656	1) How the corrective actions will be accomplished for those residents found to be affected by the practice: a) Licensed Nurses and Certified Nursing Aides assigned to resident #2 were immediately re-in-serviced on facility policy and procedure relating to ADL Support and Comprehensive Care Plans b) Licensed Nurses and Certified Nursing Aides assigned to resident # 2, were re-in-serviced individually on resident #2 plan of care c) Resident # 2 assessed immediately for any injuries and no injuries were noted. d) Resident # 2 is placed on relief turn lateral rotation system to reduce injuries. e) DON, ADON, UM, Nursing supervisors, and nurses will continue to monitor and educate CNAs. 2) How the facility will identify other	

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COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

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F 656	Continued From page 2 [redacted] and [redacted]. The Minimum Data Set (MDS), an assessment tool dated[redacted], showed that Resident #4's cognitive status was not assessed due to [redacted]. The Resident was dependent to staff for Activities of Daily Living (ADL) and required 2 staff for bed mobility and transfer. The surveyor reviewed the ADL Care Plan (CP) initiated on [redacted] with interventions initiated on [redacted] showed that Resident #2 required 2 staff assistance for bed mobility and transfer using a [redacted] Furthermore, the surveyor reviewed the CP for [redacted] related to [redacted] initiated on [redacted] which showed that the Resident required 2 persons assists with ADL's. The CP was updated on [redacted] when the facility initiated an investigation of the [redacted] with unknown origin sustained by the Resident. The Facility Reportable Event (FRE) reported to the New Jersey Department of Health (NJ DOH) on [redacted], showed that on [redacted], Resident #2 was noted with [redacted], the Attending Physician (AP) was informed and ordered a doppler examination which came back negative for [redacted] (a medical condition that occurs when a [redacted]). On [redacted], the Resident's [redacted] d requiring transfer to the hospital for further evaluation. The FRE revealed that the Resident was admitted to the hospital for [redacted] and returned to the facility on [redacted]. The facility's investigation indicated that due to the absence of	F 656	residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the deficient practice 3) What measures will be put in place or what systemic changes will be made to ensure that the deficient practice will not reoccur: Licensed Nurses and Certified Nursing Aides were in-serviced on facility Policy and procedure relating to ADL Support and Comprehensive Care Plans 4) How the facility will monitor its corrective actions to ensure that the deficient practice will not recur. What quality assurance will be put in place: a) Director of Nursing, Assistant Director of Nursing, Facility educator or designee will conduct audits to ensure Plan of Care is being followed. Audits to be done for 3 residents weekly x 4 weeks; Monthly X 3 months. b) On the spot and follow up education to be provided as needed c) Results of these audits will be presented to Administrator weekly and to QAPI committee Quarterly. Date of Compliance: Director of Nursing will ensure facility compliance is maintained. Facility is in compliance with F656 as of 11/04/2022	

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F 656	Continued From page 3 signs of [redacted], the Resident's medical condition which included [redacted], and [redacted] of the [redacted]) that were revealed on the hospital's [redacted] could have contributed to the [redacted]. There was no definitive cause of the [redacted] on the FRE and the facility indicated that the injury was unwitnessed with unknown origin. The surveyor reviewed the Documentation Survey Report (DSR), an ADL task documented by the Certified Nursing Assistants (CNA) during their assigned shift, for the month of [redacted] to [redacted]. The DSR revealed the following: Transfer: Total Dependence (TD) (4) and Support Provided (SP) One-person physical assist (2). This was documented on the following dates and shift: Day Shift 7-3 AM (DS): On 2/25/22 Evening Shift 3-11 PM (ES): On 3/25/22 to 3/27/22, and 4/3/22 Bed Mobility Extensive Assistance (EA) (3) and SP (2) This was documented on the following dates and shift: DS: On 2/1/22, 2/24/22, 3/2/22, 3/5/22, 3/9/22, 3/24/22, 3/25/22, 4/5/22, 4/6/22, and 4/8/22 Bed Mobility: TD (4) and SP (2). This was documented on the following dates and shift: This was documented on the following dates and shift: DS: On 2/27/22 and 3/1/22,	F 656		

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F 656	Continued From page 4	F 656		

ES: On 2/3/22, 2/7/22, 2/10/22, 2/15/22, 2/16/22, 2/19/22 to 2/22/22, 2/24/22, 3/2/22, 3/3/22, 3/6/22, 3/10/22, 3/11/22, 3/13/22, 3/16/22, 3/17/22, 3/19/22, 3/20/22, 3/24/22 to 3/27/22, 3/29/22, 3/31/22, 4/3/22, 4/4/22, 4/6/22, 4/8/22, 4/12/22, 4/14/22, 4/15/22, 4/18/22, 4/20/22 to 4/24/22, and 4/27/22 to 4/29/22
Night Shift 11-7 AM (NS): On 2/1/22 to 2/3/22, 2/5/22, 2/7/22, 2/922 to 2/11/22, 2/14/22, 2/16/22, 2/17/22, 2/20/22 to 2/28/22, 3/2/22 to 3/26/22, 3/28/22, 3/29/22, 3/31/22, 4/1/22 to 4/7/22, 4/9/22 to 4/16/22, 4/19/22 to 4/24/22, and 4/17/22 to 4/30/22.

The surveyor interviewed CNA #1 on 10/14/22 at 11:30 AM who stated that she had provided care to Resident #2. She recalled that the Resident had a [redacted] but could not remember the details. She explained that after the Resident sustained [redacted], she provided ADL assistance, bed mobility and transfer with another CNA to prevent new injury. CNA #1 further explained that nursing staff uses a [redacted] or [redacted] to transfer the Resident out of bed and that using the [redacted] requires 2 staff. The surveyor asked CNA #1 if she documented the task and assistance she provided for Resident #2. She answered "yes, on the kiosk." Furthermore, the surveyor showed CNA #1 the printed DSR report, she acknowledged that her initial was SE and that she documented TD (4) and SP (2) on 2/27/22, 3/1/22, 3/12/22, 3/13,22, 3/21/22, 3/22/22, 3/26/22, and 3/27/22. She stated that what she documented on the kiosk was accurate and correct. The surveyor asked CNA #1 the reason she performed the task alone on the aforementioned dates despite knowing that the Resident require 2 staff assistance after sustaining a [redacted] of unknown origin which was

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F 656	Continued From page 5	F 656		

also indicated in the plan of care to prevent new injury, she answered that due to staffing shortage, she avoided asking another nursing staff for help. However, she acknowledged that she should have asked for assistance for Resident's safety.

The surveyor interviewed the Director of Nursing (DON) in the presence of the Regional DON on 10/14/22 at 12:36 PM and they both acknowledged that there were multiple shifts on the DSR report showing 1 staff assistance was provided to Resident #2 for bed mobility and transfer. They stated that this was not in accordance with the Resident's plan of care and that the nursing staff should have provided 2 staff assistance to prevent new injury.

The surveyor reviewed the facility policy titled "Care plans, Comprehensive Person-Centered " updated 10/2021, under "Policy Statement" indicated that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062013	A. BUILDING: _____ B. WING _____	C 10/14/2022

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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S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ00151323 Based on interviews and review of pertinent facility documentation on 10/14/22, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for the weeks of 9/25/22 to 10/1/22 and 10/2/22 to 10/8/22. This was evidenced by the Certified Nursing Aid (CNA) staffing on 14 of 14-day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide to every eight residents for the day shift. The facility was deficient in CNA staffing for 14 of 14 day shifts as follows:	S 560	1) a) Center staffing ratios as required by NJDOH were communicated to staffing coordinator and all Nurse managers and supervisors to match ratios of 1:8 on day shift; 1:10 on evening shift and 1:14 on night shift b) Center staffing schedule ratios are developed, reviewed and posted two weeks prior to utilization to comply with required staffing ratios. c) Administrator, DON and Staffing Coordinator meet every morning to go over master schedule with daily staffing for the next two weeks to ensure required staffing ratios 2) All residents have potential to be affected by the same deficit practice. 3) a) If staffing deficits on master staffing schedule are identified, Center will communicate all unfilled shifts to in-house staff for coverage. b) Center will continue external recruitment efforts to fill open positions and review and revise as necessary c) Center will maintain multiple contacts with staffing agencies to meet required staffing ratios and review as necessary d) Center will continue to offer bonus structure to incentivize staff to fill shifts if needed and revise as necessary.	11/4/22

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

Electronically Signed | 11/02/22

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S 560	Continued From page 1 09/25/2022 CNA Staff was 17 for 187 residents. Staffing should have been 23 09/26/2022 CNA Staff was 17 for 187 residents. Staffing should have been 23 09/27/2022 CNA Staff was 19 for 187 residents. Staffing should have been 23 09/28/2022 CNA Staff was 17 for 187 residents. Staffing should have been 23 09/29/2022 CNA Staff was 17 for 187 residents. Staffing should have been 23 09/30/2022 CNA Staff was 17 for 190 residents. Staffing should have been 24 10/01/2022 CNA Staff was 15 for 190 residents. Staffing should have been 24 10/02/2022 CNA Staff was 16 for 187 residents. Staffing should have been 23 10/03/2022 CNA Staff was 18 for 187 residents. Staffing should have been 23 10/04/2022 CNA Staff was 17 for 187 residents. Staffing should have been 23 10/05/2022 CNA Staff was 20 for 187 residents. Staffing should have been 23 10/06/2022 CNA Staff was 18 for 187 residents. Staffing should have been 23 10/07/2022 CNA Staff was 18 for 190 residents. Staffing should have been 24 10/08/2022 CNA Staff was 20 for 191 residents. Staffing should have been 24 The surveyor interviewed the Schedule Manager (SM) on 10/13/22 at 10:10 am, she stated that she is the full times SM and also a CNA who works on the unit as needed. She further stated that she is currently working on the unit to cover for the day shift (7AM-3PM) CNA who called in sick earlier. She explained that she would offer incentives to CNA to cover extra shifts or call the agencies as needed. She acknowledged that	S 560	e) Center will continue to make efforts to retain staff by way of employee engagement events. 4) a) Center Staffing Coordinator will review projected census and staffing ratio to assure staffing compliance. b) Administrator, DON, and Staffing Coordinator will continue to meet daily to go over projected staffing to assure required staff ratios. c) If ratios are projected to not be met, Center will post openings for in-house staff as well as contact contracted agencies to maintain staffing compliance. d) DON/Staffing Coordinator will conduct daily staffing audits for two weeks and bi-weekly for two months. e) Results of the audits will be presented to the monthly QAPI meetings for review and revision as deemed appropriate. 5) Interventions for compliance with S560 are in place as of 11/04/2022 Administrator to monitor for ongoing compliance	

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	062013	A. BUILDING: _____ B. WING _____	C 10/14/2022

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S 560	Continued From page 2 CNA staffing remains a challenge specially when there's multiple call outs, but she would always try to find coverage to meet the staffing needs. The surveyor interviewed the Director of Nursing (DON) and Regional DON 10/14/22 at 12:36 pm, they both stated that the facility uses multiple CNA agencies to cover their CNA staffing demands and continues to hire CNAs and nurses. They added that the facility collaborated with CNA schools to encourage students to apply after they graduate. Furthermore, they said that staffing is improving but the staffing ratio minimum requirements remain a challenge. NJAC 8:39-5.1(a)	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
062013	A. Building B. Wing	11/17/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 11/17/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
10/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315122	A. Building B. Wing	11/17/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WESTFIELD, LLC	1515 LAMBERTS MILL ROAD WESTFIELD, NJ 07090

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0656 Reg. # 483.21(b)(1) LSC	Correction Completed 11/17/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			