STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315185	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Linwood, LLC	201 New Road and Central Ave Linwood, NJ 08221

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45209 Complaint #NJ167309 Based on interview, record review and document review it was determined that the facility failed to maintain documentation and ensure that a complete and thorough investigation was conducted for residents that had unwitnessed fall. This deficient practice was identified for 1 of 4 residents (Resident #278) reviewed for accidents and was evidenced by the following: The surveyor reviewed the medical record for Resident #278. A review of the Admission Record (AR) revealed that Resident #278 had diagnoses which included, but were not limited to, surgical aftercare following surgery on the digestive system and retroperitoneal abscess (an infection between the abdominal wall and spine). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 7/17/2023, reflected a brief interview for mental status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. Review of Resident #278's electronic medical record (EMR) Progress Notes revealed the following entries: On 07/22/2023 at 11:40 AM, a nursing progress note recorded, [Approximately] 11:35am, [.lost their] balance and fell backward. [Vital signs] taken, body assessment performed, [pt] assisted back into bed. [Neurological] checks initiated and initial assessment [within normal limits] . The surveyor requested the full fall investigation for the above identified fall. Upon review of the facility provided Accident/Incident [sic] Report Checklist, the following was identified as being submitted but was not observed by the surveyor: Registered Nurse's Statement and Neurological Assessments. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/7/2024 at 10:24 AM, Licensed Practical Nurse (LPN #1) that a Licensed Practical Nurse was responsible for obtaining vital signs of a fallen resident and the Registered Nurse (RN) would complete the full resident assessment. LPN #1 confirmed that statements are obtained from any staff member that had contact with the fallen resident including, but not limited to, the LPN, RN, Certified Nursing Assistant (CNA). and the resident. LPN #1 explained that the statement would contain a thorough description of how the resident was found any interventions that were taken. During an interview with the surveyor on 10/8/2024 at 12:42 PM, the Licensed Practical Nurse Unit Manager (LPN/UM#2) advised that neurological checks were to be initiated with any unwitnessed fall and post fall documentation is expected to continue every shift for three days. LPN/UM#2 explained that the neurological checks were completed on a paper form then submitted with the post fall incident evaluation to the Director of Nursing (DON) who would be responsible for maintaining the documents and investigation. Upon review of Resident #278 EMR, LPN/UM#2 could not identify any post fall documentation. During an interview with the surveyor on 10/9/2024 at 9:09 AM, the Director of Nursing (DON) confirmed that a thorough fall investigation was not completed since statements were not obtained (specifically from the RN that completed the fall assessment), lack of post fall documentation of the neurological checks, follow-up documentation, and signature of the title person completing the report. The DON confirmed that the importance of investigating an unwitnessed fall was to rule out abuse. A review of a facility provided policy titled Accidents and Incidents-Investigating and Reporting revealed under section Policy Interpretation and Implementation that, 2. e.) The name(s) of witnesses and their accounts of the accident or incident [.] l.) follow-up information [.] n.) the signature and title of the person completing the report . A review of a facility provided policy titled Charting and Documentation revealed under section Policy Interpretation and Implementation that, 2. The following information is to be documented in the resident medical record: a.) Objective observations; b.) Medications administered; c.) Treatments or services performed; d.) Changes in the resident's condition; e.) Events, incidents or accidents involving the resident; and f.) Progress toward or changes in the care plan goals and objectives [.]. NJAC 8:39-9.4(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 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. 45209 Complaint: NJ00167309 Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to revise a comprehensive care plan to identify the nursing intervention required to care of a surgical wound infection. This deficient practice was identified for 1 of 26 residents (Resident #278) reviewed for care planning. The surveyor reviewed the medical record for Resident #278. A review of the Admission Record (AR) revealed that Resident #278 had diagnoses which included, but were not limited to, surgical aftercare following surgery on the digestive system and retroperitoneal abscess (an infection between the abdominal wall and spine). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 7/17/2023, reflected a brief interview for mental status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. Under Section M (Skin Conditions) identified that Resident #278 had a surgical wound and surgical wound care. A review of Resident #278's Order Summary Report did not identify physician's orders for surgical wound care or maintenance of surgical wound upon admission. A review of Resident # 278's Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not identify physician's orders for surgical wound care or maintenance of surgical wound upon admission. A review of the individualized comprehensive care plan (ICCP) included a focus area area dated 7/12/2023 for enhanced barrier precautions [related to] surgical incision. The surveyor did not observe any interventions placed regarding surgical wound care. During an interview with the surveyor on 10/7/2024 at 10:24 AM, Licensed Practical Nurse (LPN #1) described a care plan as a blueprint for the resident and is used as a guideline of what works and doesn't work with the resident. LPN#1 confirmed that care plans are to be continuously updated during the resident's stay. LPN #1 identified that a care plan should identify if a resident has a surgical wound and any nursing interventions that were put into place to maintain it. During an interview with the surveyor on 10/9/2024 at 9:09 AM, the Director of Nursing (DON) acknowledged that there was no care plan update regarding the surgical wound infection. A review of a facility provided policy titled Care Plan, Comprehensive Person-Centered revealed under section Policy Explanation and Compliance Guidelines that, 8.) a. include measurable objectives and timeframes; b. Describe the services that are to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well being; 13.) Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45209 Complaint # NJ167008; NJ167309; NJ100172185 Based on interview, review of medical records and other facility documentation, it was determined that the facility failed to a.) obtain admission orders for a surgical wound b.) maintain nursing documentation of a surgical wound to prevent a delay in treatment for 1 of 26 residents (Resident #278) reviewed for wounds; c.) maintain and care for a central line catheter (tube travels through one or more veins until the tip reaches the large vein that empties into your heart) and d.) maintain treatment records that were complete with staff signatures according to professional standards of clinical practice for 2 of 26 (Resident #275 and #70) residents reviewed for medication administration and evidenced by the following: 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 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 medical regimes 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 state: 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. 1.) The surveyor reviewed the medical record for Resident #278. A review of the Admission Record (AR) revealed that Resident #278 had diagnoses which included, but were not limited to, surgical aftercare following surgery on the digestive system and retroperitoneal abscess (an infection between the abdominal wall and spine). A review of the most recent comprehensive Minimum Data Set (MDS), an assessment tool dated 7/17/2023, reflected a brief interview for mental status (BIMS) score of 13 out of 15, which indicated that the resident was cognitively intact. Under Section M (Skin Conditions) identified that Resident #278 had a surgical wound and surgical wound care. A review of Resident #278's Order Summary Report did not identify physician's orders for surgical wound care or maintenance of surgical wound upon admission. A review of Resident # 278's Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not identify physician's orders for surgical wound care or maintenance of surgical wound upon admission. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the individualized comprehensive care plan (ICCP) included a focus area dated 7/12/2023 for enhanced barrier precautions [related to] surgical incision ns. The surveyor did not observe any interventions placed regarding surgical wound care. Review of Resident #278's electronic medical record (EMR) Progress Notes revealed the following entries: On 07/12/2023 at 4:31 AM, a Nursing Progress note recorded, abdomen soft non-tender to touch with good bowel sounds surgical incision on abdomen with steri-strips intact site clean and dry [.]. On 7/12/2023 at 3:49 PM (time stamp was in bold found to be backdated and original creation date was identified as 7/17/2023 at 3:49 PM), a Nurse Practitioner progress note recorded, patient midline surgical incision [.] clean dry and intact. The surveyor did not locate any surgical wound documentation for 7/13/2023. On 7/14/2023 at 6:27 AM, a Nursing Progress note recorded, patient had some sero-sanguinous drainage (thick clear or pink fluid from a wound) from the lower end of the incision [.] area cleansed with [non sterile saline solution] and boarder gauze applied [.] lower area around [abdomen] incision is pink [.] boarder gauze noted to have sero-sanguinous [dressing] in AM so removed it & area cleansed with [non sterile saline solution] & a large boarder gauze applied [.]. On 7/14/2023 at 3:58 PM (time stamp was in bold found to be backdated and original creation date was identified as 7/17/2023 at 3:58 PM), a Nurse Practitioner progress note recorded, surgical incision has distal erythema (redness and increased blood flow) and drainage- will place [them] on antibiotic and probiotic [.] erythema to lower abdominal wound-purulent discharge (thick pus-like fluid that implies presence of infection). Upon review of the resident's MAR/TAR an antibiotic and probiotic was not submitted. On 7/15/2023 at 4:24 AM, a nursing progress note recorded, dressings to abdomen changed this shift due to dressings being soiled. The surveyor did not locate any surgical wound documentation for 7/16/2023; however, upon review of the resident's MAR/TAR, an order for cephalexin 500 milligrams (MG) was submitted for wound infection. On 7/17/2023 at 2:40 AM, a nursing progress note recorded, bandages removed from abdominal wounds, moderate amount of purulent drainage leaking from wounds, slightly thicker than water, water does have foul odor. Area cleansed and new bandages adhered to area [.]. On the same date at 3:24 PM, a nursing progress note recorded, multiple steri-strips along medical incision line with an opening the lower end of incision with a quarter size dehiscence area which has clear drainage which was cleaned and abdominal pad placed and boarder gauze placed. MD made aware of all of the above findings and resident will be evaluated in the AM. Upon review of the resident's MAR/TAR, on 7/17/2023, the surveyor identified a physician's order to keep abdominal area clean and dry with [non sterile saline solution] and apply [conventional dry dressing] two times a day for [dehiscence] (reopening) of abdominal incision. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the surveyor on 10/7/2024 at 10:24 AM, Licensed Practical Nurse (LPN #1) confirmed that new facility residents should have their admission orders reviewed with the physician to ensure continuity of care. LPN #1 further advised that a resident with a surgical wound should have order upon admission on how to care for it. When asked regarding documentation, LPN #1 stated that if the wound was not being monitored something could get missed or lead to a decline in patient status. During an interview with the surveyor on 10/7/2024 at 10:43 AM, the Infection Preventionist (IP) revealed that admission orders for any type of a wound is important because the nurses need to know how to cleanse to prevent infection. When asked what signs are and/or symptoms of infection the IP stated, redness, swelling, tenderness, warmth, drainage, pus. The surveyor inquired about the expectations of documentation regarding wounds at which the IP responded that upon admission wounds should be thoroughly documented every shift upon it's resolution. During an interview with the surveyor on 10/7/2024 at 11:51 AM, the Licensed Practical Nurse Unit Manager (LPN/UM#1) confirmed that nursing is responsible for obtaining admission orders for a surgical wound. LPN/UM #1 further explained that nursing would assess for drainage, redness, increased pain, etc every shift and document their finding appropriately. When asked why these orders were important, LPN/UM #1 responded that nursing cannot decide on their own how to treat a surgical wound. During an interview with the surveyor on 10/9/2024 at 9:09 AM, the Director of Nursing (DON) acknowledged that there were not admission orders in place to monitor the resident's surgical site. The DON confirmed that the expectation is that every shift, or minimum every 24 hours, the surgical site should be documented on. The DON also identified that the two Nurse Practitioners Progress Notes were not entered in a timely basis. Upon review the DON confirmed that nursing's documentation should have demonstrated that they closed the gap in communication to see if any interventions needed to be in place to prevent any delay in care to the resident. A review of a facility provided policy titled Change in a Resident's Condition or Status revealed under section Policy Interpretation and Implementation that, 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a(an): [.] e.) need to alter the resident's medical treatment significantly [.]. A review of a facility provided policy titled Charting and Documentation revealed under section Policy Interpretation and Implementation that, 2. The following information is to be documented in the resident medical record: a.) Objective observations; b.) Medications administered; c.) Treatments or services performed; d.) Changes in the resident's condition; e.) Events, incidents or accidents involving the resident; and f.) Progress toward or changes in the care plan goals and objectives [.]. A review of a facility provided policy titled Admission Orders revealed under section Policy Explanation and Compliance Guidelines that, The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission [.]. 33106 2. According to the Admission Record (AR) Resident #275 was admitted to the facility with the diagnose that included but was not limited to; surgical aftercare following surgery of the digestive system and diverticulitis (Inflammation of one or more pouches in the colon wall). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The surveyor reviewed the Admission Assessment (AA) dated 08/24/23, which reflected that Resident #275 was alert and oriented to person, place time and situation and had a right upper arm peripherally inserted central catheter (PICC). The surveyor reviewed the physician's orders (PO) and there were no orders for the following: PICC line catheter, catheter care, dressing changes to the PICC line site or flushes to keep the PICC line patent. The surveyor reviewed the Medication Administration Record (MAR) and the Treatment Administration Record (TAR) for the month of August 2023 and there was no documentation for the following: PICC line catheter, catheter care, dressing changes to the PICC line site or flushes to keep the PICC line patent. On 10/03/24 at 11:57 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) who stated she had been employed in the facility for 7 years. The LPN/UM explained the process for residents admitted with PICC lines. She stated that the nurse would obtain the size and measurement of PICC line from the hospital and receive orders for: measurements, dressing changes, port connector changes, flushes, and to monitor the site for s/s of infiltration or infection. The LPN/UM reviewed the residents electronic medical record (EMR) in the presence of the surveyor and confirmed that there were no physician orders for the maintenance of Resident #275 right upper extremity PICC line. The LPN stated that even if the PICC line was not being used the staff were still required to assure that the PICC line was flushed, and the dressing was changed, and the site was monitored for signs and symptoms of infection. The LPN/UM stated that dressing changes were done on admission and then weekly. She added that PICC line flushes were usually done weekly for maintenance. The LPN/UM confirmed that physician orders should have been obtained for the residents PICC line to be flushed and there also should have been dressing change orders. The surveyor reviewed the EMR and observed a Health Status Note (HSN) dated 08/25/2023 at 08:33 AM. The LPN had documented that she had flushed Resident #275's right upper extremity PICC line however there were no PO to flush the line. She also documented that the PICC line was patent, intact with no signs and symptoms of infection. On 10/03/24 at 12:26 PM, the surveyor and the LPN/UM telephone interviewed the LPN regarding the documentation in the EMR on 8/25/2023 at 08:33 AM. The LPN stated that she could not remember the details about Resident #275 and that if there were no orders to flush Resident #275's PICC line, then maybe she documented on the wrong resident. The LPN had no further details regarding her documentation or Resident #275 On 10/03/24 at 12:48 PM, the surveyor interviewed the Director of Nursing (DON) who explained that if a resident was admitted with PICC line, the nurse was responsible to find out when the PICC line was placed, confirm the PICC line's location, and length of PICC line. She stated that the nurse would be responsible to get an order from the physician for dressing changes and flushes. She stated that orders for flushes would be important to obtain to ensure that the PICC line remained patent. She also stated that it would be important to obtain orders for dressing changes to the PICC line site so that the resident was free from the potential of infection. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Care and Maintenance of Central Venous Catheter implemented 09/01/2024, which indicated that the facility would adhere to accepted standards of practice regarding the care and maintenance of venous catheters. The policy indicated that compliance guidelines would include: -Document the indication for use. -Insertion date. -Type of catheter. The policy reflected that physician orders must be obtained for specific care and maintenance instructions and documentation activities should go into the nurse's notes and/or the Medication Administration Record. The facility policy titled Central Venous Access Catheter Flushing, Locking, and Removal implemented 09/01/2024, indicated that it was the policy of the facility to ensure that central venous catheters were flushed, locked, and removed consistent with current standards of practice. Compliance guidelines include obtaining physician's orders for the type of IV solution or medication, dose, rate, and length of treatment. The policy also indicated that the procedure would be documented. NJAC 8:39-27.1(a) 49712 3.) A review of Resident # 70's Admission Record indicated Resident #70 was admitted to the facility with diagnoses which include but were not limited to Heart Failure, Type 2 Diabetes Mellitus (a condition that occurs when the body doesn't respond properly to insulin, causing high blood sugar levels), and Morbid Obesity Due to Excess Calories (a complex disease that occurs when the body stores to much fat due to an imbalance between calories consumed and calories used). A review of Resident #70's Treatment Administration Record (TAR) for March 2024 revealed a physician's order (PO) with an order date of 03/14/2024, for negative pressure therapy wound vac with Y connect to B/L [bilateral] hips, change every Mon, Wed, Fri for wound treatment. Surveyor #3 observed a blank on the TAR, there were no nurse's initials indicating the treatment was administered on 03/15/2024. Surveyor #3 observed a PO with and order date 03/07/2024 for Negative pressure therapy wound vac with Y connect to B/L hips, change every Mon, Wed, Fri for wound treatment. Surveyor #3 observed blanks on the TAR, there were no nurse's initials indicating the treatment was administered on 03/08/2024 and 03/13/2024. Surveyor #3 observed a PO with an order date of 03/07/2024 to change the wound vac canister weekly on Wednesdays. Surveyor #3 observed blanks on the TAR, there were no nurse's initials indicating the treatment was administered on 03/13/2024. Surveyor #3 observed a PO with an order date of 03/07/2024 to offload heals when in bed every shift. Surveyor #3 observed blanks on the TAR, there were no nurse's initials indicating the treatment was administered on 03/08/2024, 3/13/2024, 3/15/2024 for day shift and 3/09/2024 on night shift. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor #3 observed a PO with an order date of 04/09/2024 to check the function of an air mattress every shift. Surveyor #3 observed blanks on the TAR, there were no nurse's initials indicating the treatment was administered on 03/08/2024, 3/13/2024, 3/15/2024, 03/17/2024 for day shift and 3/09/2024 on night shift. Surveyor #3 observed a PO with an order date of 04/09/2024 to apply skin prep to bilateral heels every shift. Surveyor #3 observed blanks on the TAR, there were no nurse's initials indicating the treatment was administered on 03/08/2024, 3/13/2024, 3/15/2024, 03/17/2024 for day shift and 3/09/2024 on night shift. Surveyor #3 observed a PO with an order date 04/09/2024 to complete a pain assessment every shift. Surveyor #3 observed blanks on the TAR, there were no nurse's initials indicating the treatment was not done on 03/08/2024, 3/13/2024, 3/15/2024, 03/17/2024 for day shift and 3/09/2024 on night shift. Surveyor #3 observed a PO with an order date of 03/07/2024 to document lung sounds. Surveyor #3 observed blanks on the TAR, there were no nurse's initials indicating the treatment was administered on 03/08/2024 for day shift and 3/09/2024 on night shift. During an interview on 10/08/2024 at 09:42 AM with Surveyor #3 the Unit Manger (UM) # 1 stated, When there are blanks on the TAR it means the treatment was not signed off. When asked if there should be any blanks on the TARs, the UM replied, No. During an interview on 10/08/2024 at 02:22 PM with Surveyor #3 the Director of Nursing (DON) stated, It could mean that the nurse failed to sign out the treatment but it comes down to not documenting when asked what does it mean when there are blanks on the TAR. When asked if there should be any blanks, the DON replied, No. A Review of a facility provided policy titled Documentation of Wound Treatments dated 9/1/2024 revealed under Policy Explanation and Compliance Guidelines: that, 3. Wound treatments are documented at the time of each treatment. If no Treatment is due, an indication on the Status of the Dressing shall be documented each shift (i.e., clean, dry, intact). A review of a facility provided policy titled Charting and Documentation with a reviewed date of 1/2024 revealed under, Policy Interpretation and Implementation that, 2. The following information is to be documented in the resident medical record: b. Medications administered; c. Treatments or services performed; NJAC 8:39-27.1(a)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 38680 Complaint # NJ00177156, 00176805 Based on observation, interview, and record review, it was determined that the facility failed to ensure residents received showers as scheduled for 1 of 2 sampled residents (Resident #21), reviewed for Activities of Daily Living (ADLs). This deficient practice was evidenced by the following: On 10/03/2024 at 10:39 AM, the surveyor observed Resident #21 in the room. He/She stated they would rather be home, but had no issues with this facility. According to the Admission Record Resident #21 was admitted to the facility with diagnosis that included but were not limited to intellectual disabilities and depression. The Minimum Data Set (MDS), an assessment tool, dated 08/28/2024 reflected that Resident # 21 was moderately cognitively impaired and that resident required substantial assistance with showering. A review of the September 2024 Treatment Administration Record (TAR) for Resident #21 reflected that the Resident was scheduled for showers every Sunday and Thursday on the day shift and if the resident refused a shower, staff should document in the electronic health record and the family must be notified. The same form reflected a blank for 09/5/2024. The form also reflected an n for 09/1/2024, 09/8/2024, 09/12/2024, 09/15/2024, 09/19/2024, 09/22/2024, and 09/26/2024. There was no documentation in the Progress Notes (PN), indicating the Resident refused to take showers and/or family was notified of the refusals for the month of September. On 10/04/2024 at 1:42 PM, the surveyor interviewed the Regional Clinical Director who stated that the nurses did not document in the progress notes however they did call and speak with the sister. She acknowledged that if something was not documented it was not done. On 10/07/2024 at 10:13 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who signed the September 2024 TAR. The LPN stated that most of the time Resident #21 refused the shower and she reached out to the family however it was not documented in the progress notes. She acknowledged that she should have documented it in the progress notes. A review of the facility's policy, titled, Bath, Shower/Tub reviewed on 01/2024, reflected : The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. The same policy under Documentation revealed, The following information should be recorded on the resident's ADL record and/or in the resident's medical record. #5 If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. #6. The signature and the title of the person recording the data. NJAC 8:39-27.1(a)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Linwood, LLC	201 New Road and Central Ave Linwood, NJ 08221

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49712 Based on interview and record review it was determined that the facility failed to address the recommendations made by the Consultant Pharmacist (CP) in a timely manner. This deficient practice was identified for 3 of 5 residents reviewed for medication management (Resident #70, Resident #92, and Resident #50). The deficient practice was evidenced by the following: On 10/03/2024 at 08:48 AM the surveyor requested from the Director of Nursing (DON) the CP's recommendations for Resident #70, Resident#92, and Resident # 50, from the last 6 months. 1. A review of the Admission Record for Resident#70 revealed the resident was admitted to the facility with the diagnoses which included but were not limited to Heart Failure, and Type 2 Diabetes Mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel). On 10/03/2024 at 01:17 PM, the DON provided the surveyor with Resident #70's CP recommendation reports for April 2024 through September 2024. The CP recommendation dated 09/12/2024, indicated that the medication Carvedilol (medication used to treat blood pressure and heart failure) should be administered with food or meals. This recommendation was not completed or acted upon by the facility until 10/03/2024. The CP recommendation dated 08/16/2024, indicated there was a duplicate order for Tylenol (medication used to treat pain and/or reduce fever). This recommendation was not completed or acted upon by the facility until 10/03/2024. The CP recommendation dated 08/16/2024, indicated to correct the MiraLAX (medication used to treat constipation) dosage. This recommendation was not completed or acted upon by the facility until 10/03/2024. 2. A review of the Admission Record for Resident#92 revealed the resident was admitted to the facility with the diagnoses which included but were not limited to Palliative Care, (specialized medical care for people living with a serious illness) Rhabdomyolysis (a condition caused by muscle injury or breakdown) and Hypertension (high blood pressure). On 10/03/2024 at 01:17 PM, the DON provided the surveyor with Resident #92's CP recommendation reports for April 2024 through September 2024. The CP recommendation dated 09/17/2024 indicated that a previous recommendation made on 08/15/2024 for Morphine sulfate to write separate orders for each indication was not addresses. This recommendation was not completed or acted upon by the facility until 10/03/2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The CP recommendation dated 08/15/2024 indicated to sequence the indication for Tylenol as needed. This recommendation was not completed or acted upon by the facility until 10/03/2024. The CP recommendation dated 08/15/2024 indicated verify orders for Morphine Sulfate liquid dosage. This recommendation was not completed or acted upon until 10/03/2024. 38680 3.According to the Admission Record (AR), Resident #50 was admitted to the facility with the diagnoses which included but was not limited to hypertension and depression. The Admission Minimum Data Set (MDS), an assessment tool dated 09/02/2024, reflected that the resident had no cognitive deficits. On 10/04/2024 at 08:48 AM, the surveyor reviewed the Pharmacist Consultant (CP) comments report for Resident #50. The CP recommendation dated 09/16/2024, indicated the Ammonium Lactate (used to treat skin conditions) should be placed on the treatment administration record instead of the medication administrative record. This recommendation was not completed by the facility. The CP recommendation dated 08/27/2024, indicated that the medication Omeprazole (used to treat heartburn) should be administered on an empty stomach, at least 30 minutes before eating. This recommendation was not completed or acted upon by the facility until 10/03/2024. The CP recommendation dated 08/27/2024, indicated not to crush Guaifenesin ER (used to treat congestion) and Potassium Chloride ER. This recommendation was not completed or acted upon by facility until 10/03/2024. The CP recommendation dated 08/27/2024, indicated to identify the duration of therapy for Guaifenesin ER. This recommendation was not completed or acted upon by facility until 10/04/2024. The CP recommendation dated 08/27/24, indicated the facility should clarify the diagnosis for Atenolol (used to treat blood pressure), Furosemide (used to treat water retention), and Umeclidinium (used to treat shortness of breath, wheezing). This recommendation was not completed or acted upon by facility until 10/03/2024. The CP recommendation dated 08/27/24, indicated that acetylcysteine (used to treat congestion) should be administered separately in the nebulizer. This recommendation was not completed or acted upon by the facility until 10/03/2024. On 10/07/2024 at 11:37 AM, the surveyor interviewed the North Unit Manager who stated that each nurse manager is responsible for completing the CP's recommendations. The Director of Nursing (DON) receives the report from the CP then the DON distributes the report to the Unit Managers. The North Unit Manager stated she normally completes the CP recommendations within two days, goes through them, and contacts the physician to review the recommendations. She stated that she was running behind for Resident #50's CP recommendations. She acknowledged that the CP recommendations for Residents #70, #92, and #50 should have been completed sooner. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/09/2024 at 10:19 AM, the surveyor interviewed the DON who stated the unit managers should complete the CP recommendations within five days. The surveyor reviewed the facility provided policy titled, Medication Regimen Review, implemented 09/1/2024. The policy reflected f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. NJAC 8:39-29.3 (a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 43936 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store, label, and remove expired drugs from the facility inventory. The deficient practice was observed in 1 of 3 medication rooms and 1 of 9 medication carts reviewed under the Medication Storage Task. On 10/04/2024 at 9:26 AM, the surveyor observed the [NAME] Wing Medication Storage room in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM) #1. At that time, the surveyor observed the following concerns: Three cultures that expired on 09/23/2024. Three cultures that expired on 08/08/2024. Two urine vacutainers that expired on 06/30/2024. One 1000 milliliter (mL) bag of Dextrose solution that expired in July of 2024. Two bottles of Pantoprazole 2 milligram(mg)/mL with a use-by date of 08/30/2024. One bottle of Pantoprazole 2mg/mL with a use-by date of 09/27/2024. At that time, during an interview with the surveyor, the LPN/UM # 1 stated that all medication should have an opening date. Further, she stated that she did not know when the medication Pantoprazole expired but that it should be discarded after use. Lastly, she confirmed that the cultures and urine vacutainers were expired and needed to discard them. On the same date at 9:41 AM, the surveyor observed the [NAME] Wing odd-side medication cart in the presence of LPN # 1. At that time, the surveyor observed the bubble-package for the medication lorazepam 0.6 mg (medication used to treat symptoms of Anxiety). At that time, the surveyor observed that the paper on the back of the package was opened and torn for two tablets of lorazepam. At that time, LPN # 1 confirmed she did not look at the back of the package when she counted the medication in the morning. The LPN concluded by stating that she would notify the supervisor and discard the tablets. On the same date at 10:15 AM during an interview with the surveyor, LPN/UM # 1 said she did not know that when nurses were counting medications that they should be looking at the back of the package to ensure that the integrity of the paper that holds the medication was intact, worn, or torn. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On the same date at 10:49 AM during an interview with the surveyor, the acting-Assistant Director of Nursing confirmed that when nurses count the medications, they should be looking at the front of the package and back of the package to ensure that nothing is worn, torn, or taped. Further, she said that if it is worn or torn, the medication could be lost, and the inventory could be wrong. She said that if the package is taped, then the nurse would not know if that were the correct medication. Lastly, if the issue is observed then the medication should be discarded, and the nurse should notify the supervisors and Director of Nursing before signing that the inventory was correct. On the same date at 1:03 PM during an interview with the surveyor, the Director of Nursing (DON) said that in-service education would be conducted for all nurses individually that tape is not to be used if the package is damaged, worn, or torn. A review of the facility provided policy titled, Storage of Medications updated on 1/2024 revealed under, Policy and Interpretation that, 4. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. S 8:39-29.4 (a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51232 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to: a) properly label and date food products stored in a refrigerator, spice rack, and meat freezer; b) properly discard food products on or before the expiration date; and c) properly store food products in a manner without covers. The deficient practice was evidenced by the following: On [DATE] from 9:47 AM to 10:48 AM, the surveyor, accompanied by the Dietary Director (DD) and later at 10:47 AM joined by the Regional Dietary Director (RDD), observed the following: 1.) Next to the preparation table near the sink, the surveyor observed breadcrumbs inside a clear container labeled flour and not labeled with an open and use by date. The surveyor then observed a refrigerator referred to as the everything refrigerator. Within the refrigerator, the surveyor observed the following: 2.) A stick of butter opened to air and not labeled with an open and use by date. 3.) Two tomatoes in plastic wrap labeled with a use by date of [DATE]. 4.) One quarter pan of cooked puree pork labeled with a use by date of [DATE]. 5.) Two souffle cups filled with salad dressing that were not labeled with a use by date. 6.) A 1-gallon container of thousand island salad dressing labeled with an open date of [DATE] and use by date [DATE]. 7.) An opened, 48-ounce container of cottage cheese not labeled with an open and use by date. 8.) An opened, 32-ounce plastic bottle of lemon juice not labeled with an open and use by date. 9.) An opened, 8-pound container of feta cheese not labeled with an open date. 10.) An opened, 1-quart glass jar of minced garlic not labeled with an open and use by date. The surveyor then observed the spice rack located above the stove. The surveyor observed the following: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11.) A 16-ounce container of granulated garlic powder that was opened to the air. A 16-ounce container of ground ginger without a visible open and use by date label. A 16-ounce container of chili powder and 11-ounce container of parsley flakes, neither was labeled with an open date or use by date. An 11-ounce container of dry spice that was labeled with an open date of [DATE] and a use by date of [DATE]. An opened, 1-gallon container of soy sauce. A 1-gallon container of white vinegar, and a one quart container of gravy aid not labeled with an open and use by date. Also located on the rack above the stove, the surveyor observed: 12.) A 28-ounce bag of cream of wheat opened to air. An opened 28-ounce bag of cream of rice in plastic wrap, and two bags of 5-pound dry pancake waffle mixes opened to air and not labeled with an open and use by date. 14.) In a lower shelf under the preparation countertop, there was a 45-pound box of instant beef soup base in a plastic bag opened to air and not labeled with an open and use by date. The surveyor then observed the freezer referred to as the meat freezer. The surveyor observed the following within the freezer. 15.) Three pie crusts opened to air and not labeled with an open and use by date. 16.) One bag of opened, chicken nuggets in plastic wrap and not labeled with an open and use by date. 17.) One box of bacon opened to air and not labeled with an open and use by date. 18.) One quarter pan of vanilla pudding labeled with a use by date [DATE]. 19.) One bin filled with assorted juices with no individual expiration dates. During the observation with the DD and RDD, the DD stated that food items should be labeled with an opened and use-by date to ensure freshness. Further they said items exposed to air can become contaminated with bacteria and pose a risk for illness. Lastly, the DD said she will dispose of all the items. During an interview with the surveyor on [DATE] at 10:50 AM, the DD said every item is labeled once opened with an opened and use by date. A review of the undated facility policy titled, Dating and Labeling Policy, under Procedure revealed, 1.) Upon receiving and storing, all items must be labeled with the name of food and received date. Once opened, the label must be updated with the current date and a use by date of 3 days (including date opened) unless indicted on Labeling and Dating Protocol. The policy also revealed the following, 2.) Prepared Ready-to-eat foods are to be wrapped and labeled with the name of food and 3 days use by date (including date prepared) prior to being placed in refrigerator. 3.) All items with an expired use by date must be discarded immediately. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the undated facility policy titled, Dry Food Policy, revealed under, Procedure that, 1.) Upon delivery, all dry food items will be checked to ensure all packaging is intact and marked off against the packing slip. No torn or broken boxes, wet stains, missing labels. The policy also revealed that, 2.) Immediately after delivery, date products for proper rotation using first in and first out method, (FIFO). 3.) Keep products in original packaging or in tightly covered, clearly labeled containers. A review of the undated facility policy titled, Opened Foods and Storage Policy, revealed that 1.) All opened foods should be wrapped tightly with plastic wrap or stored in an airtight container to avoid exposure to air and contaminants. 2.) After proper wrapping, all opened items must have an opened on/made on and use by date. 3.) All opened foods must be discarded by end of day on use by date. N.J.A.C 8:,d+[DATE].2 (g)

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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. 49712 Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to A.) perform hand hygiene before applying gloves and between changing gloves and B.) failed to follow transmission-based precautions, specifically by not using a gown within a resident's room who was on transmission-based precautions. The deficient practice was observed for 1 of 2 nurses observed for Medication Administration task and 1 of 1 Resident (Resident # 425) reviewed for Transmission Based Precautions. This deficient practice was evidenced by the following: A.) On 10/03/2024 at 08:18 AM during the Medication Administration task, surveyor #1 observed Licensed Practical Nurse (LPN) # 1 putting on personal protective equipment (PPE) prior to administering medications to Resident #100. LPN# 1 did not perform hand hygiene prior to putting on gloves. On 10/03/2024 at 08:33 AM surveyor #1 observed LPN # 1 put on a pair of gloves without performing hand hygiene to place a medication patch on Resident # 32. LPN #1 then realized her pen was in her pocket to date the patch. LPN # 1 then took off the gloves and signed the patch before putting on a new pair of gloves. LPN # 1 did not perform hand hygiene between the glove change. On 10/03/2024 at 08:39 AM during an interview with Surveyor #1, LPN #1 replied Yes when asked if hand hygiene should be performed prior to putting on gloves. When asked if she had done that, LPN#1 replied, No. On 10/08/2024 at 12:31 PM during an interview with Surveyor # 1 the Infection Preventionist (IP) stated, Hand hygiene should be performed before and after using gloves, after using the bathroom, before and after eating, and any time visibly soiled. On 10/08/2024 at 02:22 PM during an interview with Surveyor # 1, the Director of Nursing (DON) replied Yes when asked if hand hygiene is required prior to putting on gloves and during glove changes. A review of a facility provided policy titled Administering Medications with a revised date of 1/2024 revealed under Policy Interpretation and Implementation that, 12. Staff shall follow established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for administering medications, as applicable. A review of a facility provided policy titled Handwashing/Hand Hygiene with a revised date of 1/2024 revealed under Policy Interpretation and Implementation that, 2. All personal shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personal, residents, and visitors; 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: b. Before and after direct contact with residents; m. After removing gloves; 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as best practice for preventing healthcare-associated infections. 51232 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B.) On 10/04/2024 at 8:30 AM, Surveyor #2 from the hallway observed Registered Nurse (RN) #1 inside Resident # 425's room. At that time, Surveyor # 2 observed a sign on the room door that revealed Resident # 425 was on Contact Precautions. The sign had instructions that revealed a gown must be worn while inside the room. RN # 1 was not wearing a disposable gown while in the room. A review of Resident # 425's physician's orders located in the Electronic Medical Record revealed he/she had an order to maintain contact isolation precautions related to Group B Streptococcus (a highly contagious bacteria) and Methicillin Resistant Staphylococcus Aureus (a multi-drug resistant pathogen) in a wound located on the Resident's knee. The order revealed that, nurse to ensure proper isolation equipment is present: stop sign on door, supplies (gown, gloves, mask) are in the bin outside room . During an interview with Surveyor # 2 on 10/04/2024 at 8:35 AM, RN # 1 said she was not wearing a gown. RN # 1 then said she should be wearing a gown to protect herself and the resident from infection. During an interview with surveyor on 10/04/2024 9:03 AM, the Director of Nursing (DON) said if someone is on contact barrier precautions the nurses should be wearing personal protective equipment (PPE) while completing wound care. During an interview with surveyor on 10/04/2024 1:43 PM, Licensed Practical Nurse/Unit Manger (LPN/UM#1) said nurses should wear PPE when completing wound care for residents on contact or enhanced precautions to protect themselves. A review of a facility policy dated 09/01/2024 titled, Transmission-Based (Isolation) Precautions, revealed under contact precautions letter c, Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. N.J.A.C. S 8:39-19.4(a)