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	02/19/2026

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 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. Based on observation, interview, and policy review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 02/12/2025 from 09:12 AM until 10:20 AM, the surveyor observed the following in the kitchen in the presence of the Regional Food Service Director (RFSD):1. In the dry storage closet an open bag of gelatin mix wrapped in plastic wrap and an opened bag of potato chips had no labeled open or used by date. The RFSD acknowledged it should be dated, and the items were removed. 2. The high-temperature dishwasher is set to operate between 150 F and 180 F, the final rinse temperature should be 180 F. The surveyor observed the wash temperature at 134 F, the RFSD confirmed the temperature and indicated it should be 150 F. The final rinse temperature was recorded as 150 F, the RFSD confirmed the machine was not at operational temperature and indicated the temperature should be180 F. The dishwasher was immediately stopped upon discovery of the temperature discrepancy. On 2/12/2026 at 09:45 AM during the kitchen tour the dishwasher temperature log was noted to have part of the lunch log entered. On the same day at 11:43 AM during interview with Dietary aide #1 (DA #1), when asked why the log for the afternoon temperatures was partially filled in before the lunch hour DA #1 indicated that it was a mistake and that they had got ahead of themselves. On 02/12/26 at 11:24am, upon return to the kitchen, boxes containing food products were observed stacked on the floor. Uncooked meat products were observed stacked with boxes of food products. The RFSD stated the boxes were from their recent delivery and should not be resting on the floor. The surveyor reviewed the facility provided policy titled, Dating and Labeling Policy with revision date January 2026 which reflected: for the kitchen to ensure food safety by maintaining proper dates and labels to all ready to eat food products. Use a black marker or date gun with legible writing to date and label products. Discard all foods that expire immediately. The surveyor reviewed the policy titled, Sanitization with revision date January 2023 which reflected the high-temperature dishwasher (Heat Sanitization) should reach a wash temperature of (150 F-165 F) and rinse temperature (165 F-180 F).The surveyor reviewed the policy titled, Food Preparation and Service with revision date January 2026 which reflected food in designated dry storage areas shall be kept off the floor (at least 18 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents. NJAC 8:39-17.2(g)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to provide a sanitary environment for residents, staff, and the public by failing to keep the garbage container area free of garbage and debris and failed to have a closed cover over the opening of 1 of 3 garbage containers. This deficient practice was evidenced by:On 02/12/2026 at 10:11 AM, the surveyor, accompanied by the Regional Food Service director (RFSD), observed the facility's outdoor trash disposal area. The surveyor observed three garbage containers (GC) situated at the rear of the property. One of the GCs had an open lid and contained trash which was exposed to the elements, and another GC observed overflowing with refuse. The area surrounding the three GCs was littered with debris, including but not limited to cardboard boxes and milk crates.On 02/17/2026 at 11:04 AM, during an interview with the surveyor, the Environmental Service Supervisor (EVSS) stated that the GCs should remain free from debris and the lids should be closed. The EVSS stated that the GCs are monitored by maintenance but should be a team effort. On 02/18/2026 at 09:47 AM, during an interview with the surveyor, the Director of Maintenance (DOM) stated that both housekeeping and the maintenance departments are responsible for maintaining the GC area. The DOM stated the GCs are checked daily and will alert Environmental Services to clean up the area when necessary.The surveyor requested trash or refuse policies on 02/12/26 at initial tour and again on 02/18/26 at 10:22 AM, the facility failed to produce a policy. NJAC 8:39-19.3(c)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and facility provided documentation, the facility failed to ensure residents were treated with dignity and respect during A.) incontinence care for 1 of 2 (Resident # 10) and B.) 3 of 3 dining rooms observed during the Dining Task.This deficient practice was evidenced by the following:A) During initial tour on 02/12/2026 at 9:23 AM, the surveyor observed Resident #10 in bed wearing two incontinence briefs. During an interview at the same time with the surveyor, the certified nurse's assistant (CNA) #1 said that they are not supposed to be wearing two incontinence brief. CNA # 1 said that the overnight staff are responsible. She concluded saying when we come and find it, we report it to the nurses.A review of Resident #10's admission record revealed that Resident # 10 was admitted to the facility with diagnoses of but not limited to, Dementia (a syndrome characterized by a decline in cognitive function), and type 2 diabetes.A review of Resident # 10 Minimum Data Set (MDS) dated [DATE] revealed under section H that Resident # 10 was always incontinent of bowel and bladder. A review of Resident # 10's Care Plan did not include any interventions for Resident # 10 to wear two incontinent briefs until after being brought to their attention by the surveyor. During an interview on 02/18/2026 at 12:02 PM with the surveyor, the Director of Nursing (DON) said that residents should not be wearing two incontinence briefs. B). On 2/13/2026 at 8:59 AM, the surveyor observed 5 residents eating breakfast in the south wing day room. All five residents were served on trays. During an observation of dining on 02/13/2026 at 12:21 PM in the south unit day room, the surveyor observed 8 residents being served lunch. All 8 residents were served their lunch on trays; there were no table clothes on the tables. The meals were left on the trays for the meal. During an observation of dining on 02/13/2026 at 12:28 PM in the south wing dining room the surveyor observed 8 residents all sitting at one table eating lunch off of trays.During an interview on 02/13/2025 at 12:33 PM with the surveyor, Licensed Practical Nurse # 1 (LPN) said that they usually serve the meals on trays in the dining room. When asked if that was conducive with a homelike environment, the LPN replied, no. A review of a facility provided policy updated January 2026 and titled, Dignity revealed, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem, and when assisting with care, residents are supported in exercising their rights. For example, residents are: Provided with a dignified dining experience. NJAC 8:39 - 4.1(a)12

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review and facility provide documentation, the facility failed to ensure staff and vendors utilized appropriate personal protective equipment (PPE) during resident care in accordance with facility policy and accepted standards of infection control practice.This deficient practice was evidenced by the following:During initial tour on 02/12/2026 at 10:12 AM surveyor #1 observed an ultrasound technician (UT) performing an ultrasound on Resident # 152 while in their room. The door to room indicated that the resident was on enhanced barrier precautions (a set of rules where nursing home staff wear gowns and gloves during high-contact care for certain residents to stop the spread of dangerous germs). The ultrasound technician was observed not wearing a protective gown while performing an ultrasound. A review of Resident # 152's electronic medical record (EMR) revealed that Resident #152 was admitted to the facility with a diagnosis of but not limited to prostate cancer, and obstructive and reflux uropathy (a blockage in the urinary tract that impedes urine flow). A review of Resident # 152's Care Plan revealed a focus for enhanced barrier precautions for a suprapubic catheter. During an interview on 02/12/2026 at 10:22 AM with surveyor #1, the ultrasound technician said the nurses did not inform her that the resident was on any precautions. When asked if the UT saw the sign on the door, she replied I didn't look. During an interview with surveyor #1 on 02/18/2026 at 9:43 AM, the Infection Preventionist (IP) said that all outside venders are required to wear Personal Protective Equipment (PPE), while performing any kind of care on the residents. The IP also said there are signs on the door to alert visitors and venders that they need to wear PPE, and if they have any questions to ask the nurses. During an interview on 02/18/2026 at 12:02 PM with Surveyor # 1, the Director of Nursing (DON) said, all vendors should follow the signs we have placed on residents' doors regarding Enhanced Barrier Precautions. To ensure germs are not spread. A review of a facility provided policy titled, Enhance Barrier Precautions (EBP) revealed under Initiation of EBP that b. an order for EBP will be obtained for a resident with any of the following, wounds, and or indwelling medical devices. the policy also revealed under, Implementation of EBP to, Provide education to residents and visitors. N.J.A.C. 8:39-19.4(a) On 02/13/2026 at 11:34 AM during a tour of the [NAME] Unit, Surveyor # 2 observed Certified Nurses Aide (CNA) # 1 inside Resident # 102's room. Outside of the doorway of the room was a sign indicating the room required Enhanced Barrier Precautions (a set of rules where nursing home staff wear gowns and gloves during high-contact care for certain residents to stop the spread of dangerous germs). At that time, the surveyor observed bed sheets on the floor, the privacy curtain half-way drawn, and CNA # 1 operating the bed remote control of Resident # 102 who was laying in the bed. CNA # 1 was not wearing a protective gown or disposable gloves. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Upon exiting the room, during an interview with Surveyor # 2, CNA # 1 replied, Yeah, I should've when asked if she should have been wearing a disposable gown and gloves. CNA # 1 confirmed that she worked as a CNA in the facility but was employed by a staffing agency. A review of Resident # 102's Electronic Medical Record under Orders revealed a physician's order for Enhanced Barrier Precautions for every shift. The order was started on 09/20/2025. A review of the undated facility-provided policy titled, Enhance Barrier Precautions revealed that High-contact resident care activities include: a. Dressing, b. Bathing, c. Transferring, d. Providing hygiene, e. Changing linens, f. Changing briefs or assisting with toileting . N.J.A.C. 8:39-19.4(a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of other facility-provided documentation, it was determined that the facility failed to maintain a clean and sanitary environment for 1 of 4 units (South). This deficient practice was evidenced by the following: On 02/12/2026 during the initial tour, Surveyor # 2 observed the following: At 10:56 AM, Surveyor # 2 observed the Sub-Acute soiled utility room. There was a filled garbage bag on the floor garbage overflowing from the receptacle bin. At 11:02 AM, Surveyor # 2 observed the soiled biohazard room across from room [ROOM NUMBER]. There were filled garbage bags left on floor. A 11:08 AM, Surveyor # 2 observed the biohazard room located in the secured unit. There were filled garbage bags on floor. Also at that time, the surveyor observed a broken hand sanitizer dispenser next to room [ROOM NUMBER]. During initial tour on 02/12/2026 at 9:12 AM, the surveyor observed the following on the South Unit: An incontinence brief and used disposable glove on the floor near a trash bin with no trash bag, filled trash bags directory on the floor, and a broken tile on the floor in the biohazard room. In room [ROOM NUMBER] A, the molding was missing from the middle of the wall. On 02/18/2026 at 12:02 PM during an interview with the surveyor, the Director of Nursing (DON) said there should not be missing molding in the rooms, and trash on the floor, because it's not a homelike environment. She concluded by saying it can cause germs to spread in the facility. A review of a facility provided policy titled Safe and Homelike environment revealed, in accordance with resident's rights, the facility will provide a safe, clean, comfortable and homelike environment. N.J.A.C. 8:39-31.4(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. Based on observation, interview, record review, and review of other pertinent facility documentation, the facility failed to ensure a resident who is unable to carry out activities of daily living (ADL) received the necessary facial care to maintain proper grooming and personal hygiene. The deficient practice was observed for 1 out of 3 residents reviewed for Activities of Daily Living, (Resident #153).The deficient practice was evidenced by the following:On 2/12/2026 at 10:37 AM, during the initial tour of the facility, the surveyor observed Resident #153 resting in bed wearing a hospital gown. The resident's face had thick and untrimmed beard and moustache about 2 inches long. Their hair appeared oily and unkempt. There was a malodorous smell in the room. On 2/13/2026 at 11:38 AM, the surveyor observed the resident in bed wearing a hospital gown. The resident's face was shaven. Their hair appeared oily and unkempt. The resident stated to the surveyor that they did not want to go to the shower but wanted their face shaved. The resident stated that they had been in the facility for two weeks already but have not been offered to get shaved until that day. The resident denied that they were offered alternative to having a shower such as a bed bath or a hair wash in bed. The surveyor reviewed the electronic medical record (EMR) for Resident #153.A review of the admission Record face sheet (an admission summary) reflected that Resident #153 was admitted to the facility with diagnoses which included but were not limited to; legal blindness, cellulitis (a bacterial skin infection) of the right and left lower limbs, and abnormalities of gait and mobility.A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 2/10/2026, revealed an intact cognition. Further review of the MDS revealed that the resident required maximum assistance in bathing and moderate assistance in their personal hygiene which included shaving.A review of the resident's individualized comprehensive care plan initiated on 2/5/2026, revealed that the resident required assistance in completing their Activities of Daily Living (ADL) such as showering and shaving.A review of the Progress Notes (PN) and Medication/ Treatment Administration (MAR/ TAR) notes did not include any documented refusal of care from admission date to the time of surveyor inquiry on 2/12/2026. On 2/13/2026 at 11:42 AM, during an interview with the surveyor, Certified Nursing Assistant (CNA) #1 stated that they never had Resident #153 in their assignment before. They also stated that the resident asked them to be shaved because the resident did not want a beard and moustache. CNA #1 further stated that the resident refused to have a shower that day.On 2/17/2026 at 11:46 AM, during an interview with the surveyor, CNA #2 stated that when residents refuse to shower, they offer bed bath or hair wash in bed. CNA #2 further stated that they also report to their supervisor when residents refuse care. CNA #2 stated that shaving is part of their care. On 2/17/2026 at 11:47 AM, during an interview with the surveyor, Licensed Practical Nurse (LPN) #1 stated that when residents refuse shower, they offer alternative time to give the residents shower. LPN #1 also stated that they document refusal of care in the MAR, PN, or on the 24-hour report. On 2/17/2026 at 11:57 AM, the surveyor reviewed the nursing 24-hour reports for February 2026. There was no documented refusal of care for Resident #153.On 2/17/2026 at 8:38 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that showers are scheduled upon admission. The DON stated that when a resident refuse shower or care, the nurses should report to the unit managers, offer a different shower time and document refusal in the EMR. The DON further stated that shaving is part of care on shower days and as needed.A review of facility-provided undated policy titled ADL Policy included under Procedure the following: 10.) A patient who requires Moderate Assistance depends on the assistance of the staff to complete about half of the activity. 11.) A patient who requires Maximum Assistance depends on the assistance of the staff in order to complete a large portion of the activity. Staff members will perform majority of the activity with the patient assisting as much as he/ she is able. N.J.A.C. 8:39 - 27.1 (a), 27.2 (d) (g) (h)

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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. Based on observation, interview, review of medical record and other pertinent facility documents, it was determined that the facility failed to ensure that a resident who was identified as having a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity or rigidity of joints) received services to prevent further decreased range of motion (ROM) after discharge from therapy. This deficient practice was identified for 1 of 2 residents reviewed for position and mobility, (Resident #12) and was evidenced by the following: On 2/12/2026 at 9:43 AM, during the initial tour of the facility, the surveyor observed Resident #12 alert but non-verbal and resting in bed. The resident was mechanically ventilated via tracheostomy (a surgical opening in the neck created with a tube to keep the airway open for breathing). The surveyor noted the resident's right hand flexed from the wrist and the right fingers flexed in a fist. The fingernails of the right hand were observed to be trimmed. No positioning device was observed on the resident's right hand. There was no hand splint or roll noted on the resident's person, bed and room.On 2/13/2026 at 12:12 PM, the surveyor observed the resident sleeping in bed. The resident's right fingers were flexed into a fist. There was no hand splint or hand roll noted on the resident's person, bed and room.On 2/17/2026 at 10:18 AM, the surveyor observed the resident in bed together with Unit Manager/ Registered Nurse (UM/ RN) #1. The resident's right fingers were flexed into a fist. There was no hand splint or hand roll noted on the resident's person, bed and room. The surveyor asked UM/ RN #1 if they could look at the resident's right palm. UM/ RN #1 stated that the resident's right hand was contracted. The resident's right palm was observed to be intact and dry with no discoloration. The surveyor reviewed the medical record for Resident #12.A review of the admission Record face sheet (an admission summary) reflected that Resident #12 was admitted to the facility with diagnoses which included but were not limited to; chronic respiratory failure, dependence on respirator status, anoxic brain damage (damage to brain after being deprived of oxygen), and unspecified contracture.A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 1/28/2026, revealed severely impaired cognitive skills for daily decision making and unspecified contracture. Further review of the MDS reflected no participation on physical therapy (PT), occupational therapy (OT) or restorative nursing program (RNP). The MDS also indicated that no splint or brace assistance was applied for Resident #12.A review of the Order Summary Report (OSR) active as of 2/17/2026, did not reveal any active or discontinued order for devices used for positioning of the right hand. Further review of the OSR revealed that an order for evaluation and treatment for OT was discontinued on 10/10/2022.A review of the miscellaneous and therapy tabs in the electronic medical record (EMR) did not reveal any therapy reports, past or active for the resident.A review of the resident's individualized comprehensive care plan initiated on 4/24/2023, reflected a focus for limited mobility which did not include any intervention to prevent worsening of the resident's contracture on the right hand.On 2/17/2026 at 8:40 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that physical and occupational therapists put their recommended orders in queue on the EMR which the nurses would confirm if the physician agreed to the order. The DON confirmed to the surveyor that the facility did not have a program for restorative services. On 2/17/2026 at 9:57 AM, during an interview with the surveyor, UM/ RN #2 stated that therapy reports are located under the therapy or miscellaneous tab of the EMR. On 2/17/2026 at 10:04 AM, during an interview with the surveyor, the Director of Rehabilitation (DOR) was asked for the most recent PT or OT service reports for Resident #12. No OT/ PT service reports were provided to the surveyor. The DOR was also asked what positioning device the resident had. The DOR stated that the patient (Resident #12) did not have any positioning device because of the risk for wounds. The DOR stated that when the therapists evaluate a patient, the orders go to the EMR.On 2/19/2026 at 10:16 AM, during an interview with the survey team, the DON stated that Resident #12 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be started on OT service. The DON provided the surveyor with a copy of the OT Evaluation and Plan of Treatment (OTEPT) report for certification period 2/18/2026 to 5/11/2026, a period after the surveyor inquiry about the resident's contracture. A review of the OTEPT included a new goal for the patient to safely wear bilateral palm rolls 4 hours on/ 4 hours off without skin irritation to improve PROM (passive range of motion) for adequate hygiene and reduce pain caused by joint deformity.No PT/ OT policy was provided addressing rehabilitation services to the residents. N.J.A.C. 8:39-27.1(a), 27.2(m)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, record review and review of other pertinent facility records, it was determined that the facility failed to accurately implement a physician prescribed fluid restriction order for 1 of 1 resident's (Resident #11) reviewed for dialysis. This deficient practice was evidenced by the following:On 02/13/2026 at 08:59 AM the surveyor observed and interviewed Resident #11 in his/her room. Resident #11 stated that he/she has been receiving dialysis for about 2 months. The surveyor observed a bottle of diet soda, a bottle of water, a carton of milk, a small juice cup, and two clear glasses of a pink colored beverage on the resident's bedside table tray. The surveyor questioned Resident #11 whether he/she was on a fluid restriction. Resident #11 replied that they were unsure if they were. A review of Resident #11's admission Record revealed that, Resident #11 was admitted to the facility with diagnoses including but not limited to: Chronic Kidney Disease Stage 4 (kidneys no longer work as they should to meet your body's needs) and dependence on renal dialysis (a treatment to clean your blood when your kidneys are not able to).A review of Resident #11's Order Summary Report revealed active orders as of: 2/13/2026, Resident #11 had the following physician's orders:1500 fluid restriction for nutrition. Dialysis on: Tuesday, Thursday and Saturday at Fresenius Kidney Care. Chair time 5:40AM.According to Resident #11's comprehensive care plan, Resident #11 had a Focus of: Dialysis related to renal failure, Date Initiated: 12/04/2025. The following was revealed under Goal: Monitor Intake and Output, date initiated 12/04/2025.Review of the nutrition evaluation dated 11/30/2025, reflected that the resident should continue with liberal diabetic, renal diet, monitor intake and resident will consume at least 75% of fluids offered. The most recent dietician note dated 12/30/2025 indicated to continue with current diabetic/renal diet with 1500cc fluid restriction prescribed by MD.The facility failed to provide an active diet slip when asked, one was written in the presence of the surveyor. On 2/17/2026 at 10:46 AM, during a telephone interview, the Registered Dietician (RD) indicated to the surveyor that fluid restrictions are monitored by the nursing and dietary. An interview with Licensed Practical Nurse #1 (LPN #1) on 02/17/2026 at 11:27 AM indicated that LPN #1 was unaware that Resident #11 had a fluid restriction. When questioned how fluid restricted residents' fluids were monitored LPN #1 stated that they take note of what is on the resident's tray and what fluids the aides provide. LPN #1 also indicated that resident #11 is able to let staff know how much he/she has drunk that day. Follow up interview with LPN #1 on 02/17/2026 at 12:19 PM when asked if resident #11's fluid consumption was being documented and where it could be found, LPN #1 stated they would be found in the progress notes or the 24-hour communication book. LPN #1 stated that there would be required documentation of resident's intake and output only if the physician ordered Intake and Output monitoring, further stating that Resident #11's fluid restriction was part of the diet order so there would be no documentation of Resident #11's fluid intake and output. Review of the 24-hour communication book revealed no documentation of resident #11's fluid intake and no progress notes provided any documentation of Resident #11 fluid intake. On 02/18/2026 at 12:02 PM during interview the Director of Nursing (DON) when asked where fluid observations should be documented the DON stated they should be documented in the residents Medication Administration Record (MAR) and/or Treatment Administration Record (TAR). The DON further stated that residents that are care planned to Monitor Intake and Output should have fluid observations documented on the residents MAR or TAR.Review of the policy titled Fluid Restriction revision date May 2021 reflects; The nursing department will document the amount of fluids the resident receives.Review of the policy titled Nursing Documentation revision date April 29, 2020, revealed under the heading Policy Statement: It is the policy of this facility for nursing documentation to be completed in the Electronic Medical Record (EMR) and/or nurse notes located in the resident's chart.N.J.A.C. 8:39-27.1 (a)

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	02/19/2026

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 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. Based on observation, interview, and review of medical record and pertinent facility documents, it was determined that the facility failed to a.) label and store treatment medications securely inside the treatment cart for 1 unsampled resident (Resident #25), b.) monitor the temperature of refrigerated drugs and biologicals in 1 out of 5 medication rooms (north wing) inspected , and c.) store medications securely in their packaging inside the medication carts for 2 out of 5 medications carts (north wing front cart and east wing even cart) inspected during the medication storage and labeling task. The deficient practice was evidenced by the following: 1.) On 2/12/2026 at 10:15 AM, during the initial tour of the facility, the surveyor observed Resident #25 in bed connected to a mechanical ventilator (a life-support machine that assists a person to breathe). The surveyor observed an uncapped, unlabeled, and unbagged 4-ounce tube of zinc oxide ointment on top of the overbed table located at the foot of the resident's bed. The surveyor also observed an uncapped, unlabeled, and unbagged 4-ounce tube of Vitamin A&D ointment on the windowsill to the right of the resident's bed. At the time of observation, the surveyor asked RN #1 if the treatment medications should be stored in the resident's room. RN #1 replied that the medications should have been labeled and stored inside the treatment carts. RN #1 stated that they were going to dispose of the 2 tubes. RN # further stated that the resident and their roommate were both unable to get up and transfer by themselves.The surveyor reviewed the electronic medical record of Resident #25.A review of the admission Record face sheet (an admission summary) reflected that Resident #12 was admitted to the facility with diagnoses which included but were not limited to; cerebral palsy (motor disorder caused by abnormal brain development), dependence on respirator status and persistent vegetative state.A review of the most current comprehensive Minimum Data Set (MDS), an assessment tool dated 2/11/2026, revealed that the resident was at high risk for skin injuries and was fully dependent on staff for all their activities of daily living including transfers. A review of Order Summary Report (OSR) active as of 2/13/2026, reflected a physician order for Zinc Oxide every shift that was discontinued on 1/8/2026. The OSR did not show any active or discontinued physician order for Vitamin A&D ointment.A review of the resident's individualized comprehensive care plan initiated on 11/25/2025, reflected a focus for high risk of skin alteration related to immobility which included an intervention for barrier cream as needed.On 2/17/2026 at 8:38 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that zinc oxide and A&D ointments should be stored in the treatment carts for privacy and infection control.On 2/17/2026 at 1:25 PM, during an interview with the surveyor, the Consultant Pharmacist (CP) stated that treatment tubes should be labeled with the resident's name, capped, bagged and kept in the treatment carts. CP further stated that treatment tubes should be labeled with residents' names because they cannot be shared with other residents. A review of facility-provided policy updated in June 2023, titled Medication Labeling and Storage reflected under Policy the following: The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Under Medication Storage, the following was included: 5.) Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.2.) On 2/12/2026 at 11:12 AM, the surveyor toured the north wing medication room with RN/ UM #2. The surveyor observed warm air inside the refrigerator when it was opened. Located inside the refrigerator were the following medications and biologicals: 6 bags of 100 milliliter daptomycin 500 mg, 4 bags of 500 milliliter intravenous saline solution (0.9%) with 4 vials of powdered vancomycin 1.5 grams, 2 unopened and 1 opened vials of Aplisol solution, 10 boxes of Fluarix influenza vaccines containing 10 vials/ box. The surveyor asked RN/ UM #2 what the temperature inside the refrigerator was. RN/ UM (continued on next page)

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	315185	A. Building B. Wing	02/19/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#2 could not locate the thermometer inside the refrigerator. RN/ UM #2 stated that there should have been a thermometer inside the refrigerator and that they did not know what happened to it. RN/ UM #2 was observed to get a thermometer and placed it inside the first refrigerator.On 2/17/2026 at 8:40 AM, during an interview with the surveyor, the DON stated medication refrigerators need an internal thermometer to keep the temperature of medications according to manufacturer's recommendation. The DON also stated that the facility process was to keep the internal temperatures at 38 - 40'F.On 2/17/2026 at 1:23 PM, during an interview with the surveyor, the CP stated that medication refrigerators should have internal thermometers to make sure that the temperatures of medications were within the range recommended by manufacturers.A review of facility-provided policy updated in June 2023, titled Medication Labeling included the following under Policy: The facility stores all medications and biologicals in locked compartments under proper temperatures, humidity and light controls.3.) On 2/13/2026 at 10:02 AM, during an inspection of the north wing front cart with RN/ UM #2, the surveyor observed 5 loose tablets inside the drawer of the medication cart. RN/ UM #2 stated that there shouldn't be loose tablets in the cart. RN/ UM #2 stated that the loose tablets should be disposed of in the drug disposal bottle located in the medication cart. On 2/13/2026 at 11:45 AM, during an inspection of the east wing even cart with RN/ UM #1, the surveyor observed 3 loose tablets inside the drawer of the medication cart. RN/ UM #1 stated that there should not be loose tablets in the cart. RN/ UM #1 stated that the loose tablets should be disposed of in the drug disposal bottle located in the medication cart. On 2/17/2026 at 8:42 AM, during an interview with the surveyor, the DON stated that there should not be loose tablets in the cart and that the nurses should be removing loose tablets from the cart.On 2/17/2026 at 1:27 PM, during an interview with the surveyor, the CP stated that there should not be loose tablets in the medication cart and that the nurses should be disposing them as they find them.A review of the facility-provided policy updated in June 2023, titled Medication Labeling and Storage indicated under Policy Interpretation the following: 1.) Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. N.J.A.C. 8:39 - 29.4 (a) (h)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on observation, interview, and record review, it was determined that the facility failed to ensure that infection control education was provided and documented for 1 of 1 agency staff members (CNA; Certified Nurse Aide) # 1 providing care to a resident in a room requiring Enhance Barrier Precautions (EBP). The deficient practice was evidenced by the following: On 02/13/2026 at 11:34 AM during a tour of the [NAME] Unit, Surveyor # 2 observed Certified Nurses Aide (CNA) # 1 inside Resident # 102's room.Outside of the doorway of the room was a sign indicating the room required Enhanced Barrier Precautions (EBP; a set of rules where nursing home staff wear gowns and gloves during high-contact care for certain residents to stop the spread of dangerous germs). At that time, the surveyor observed bed sheets on the floor, the privacy curtain half-way drawn, and CNA # 1 operating the bed remote control of Resident # 102 who was laying in the bed. CNA # 1 was not wearing a protective gown or disposable gloves. Upon exiting the room, during an interview with Surveyor # 2, CNA # 1 replied, Yeah, I should've when asked if she should have been wearing a disposable gown and gloves. CNA # 1 confirmed that she worked as a CNA in the facility but was employed by a staffing agency. A review of Resident # 102's Electronic Medical Record under Orders revealed a physician's order for Enhanced Barrier Precautions for every shift. The order was started on 09/20/2025. A review of CNA # 1's facility-provided orientation and competency information revealed only one document titled, Welcome to [Facility Name] Healthcare. The document including information about reporting allegations of abuse and reporting protocols. The document did not reveal information about infection control practices, procedures, protocols, or policies. The document concluded with CNA # 1's signature that acknowledged she received mandatory in-servicing prior to employment. On 02/18/2026 at 11:38 AM during an interview with the surveyor, the Director of Nursing (DON) explained that when agency-contracted CNAs come to the facility, they make rounds with the facility educator. The CNA is shown the facility and units. The DON said the facility discusses infection control with the CNAs. At that time, the surveyor requested the documentation confirming the CNA received infection control education. The DON confirmed they did not document the education and that it is delivered verbally. On 02/19/2026 at 10:07 AM during another interview with the surveyor, the DON said agency-contracted staff orientation includes receiving a facility tour, education on resident needs, infection prevention and control practices, the location and use of personal-protective equipment (PPE), hand-hygiene expectations, and a review of isolation and enhanced-barrier precautions. The DON continued that the facility clearly posted EBP signs outside resident rooms and that the sign includes step-by-step instructions. The DON concluded saying that the signs and personal protective equipment are clearly visible and understandable for all level of staff. At that time, the surveyor requested the documentation that the aforementioned education was provided to CNA # 1. The DON stated, No documentation, only verbally. A review of the facility-provided policy updated January 2026, titled, Policy for Orienting Agency Staff to the SNF for Agency CNA's. The policy statement revealed, It is the policy of this facility to ensure that all agency staff have a facility onboarding process to ensure the safety and wellbeing of the residents that reside in the facility. The policy also revealed that, The agency staff should be provided with a copy of the census for the side they are assigned to. This document will help them understand the patient population and their specific needs . N.J.A.C. 8:39-19.4(b)