STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Fair Lawn Edge	77 East 43rd Street Paterson, NJ 07514

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on the interview and review of other facility documentation, it was determined that the facility failed to issue the Notice of Medicare Non-coverage (NOMNC, which is an official document issued by Medicare-certified healthcare providers and serves as a formal notice informing beneficiaries about the termination or denial of coverage for specific health care services) or Form CMS - 10123, required notice for 1 of 3 residents (Resident #182) reviewed for beneficiary notification. This deficient practice was evidenced by the following On 8/11/25 at 10:51 AM, the surveyor reviewed the NOMNC or Form CMS -10123 review completed by the facility for Resident #182 as follows: A review of the Progress Notes (PN) dated 4/9/25 at 4:19 PM stated that the resident was transferred to another health care facility. A review of the electronic Medical Records (eMR) revealed that there was no documented evidence that the NOMNC was done, nor the reason why it was not done. A review of the physician certification and re-certification form with a handwritten name of Resident #182 and with a handwritten discharge date of 4/9/25, signed by the physician on 3/29/25. A review of the NOMNC letter provided by the Licensed Nursing Home Administrator (LNHA) on the same day revealed a handwritten name of the resident stating the effective date coverage of your current: skilled nursing services will end with a handwritten date of 4/18/25. Resident #182's name signed the letter with the date on 4/16/25. On 8/11/2025 at 11:28 AM, the surveyor interviewed the Director of Social Services (DSS), who stated that the NOMNC form should be signed at least 72 hours or 2 days before the resident will be discharged to home or other facility. The DSS did not provide additional information on why the date was not correct on the letter. On 8/11/2025 at 12:05 PM, the surveyor interviewed the LNHA, who stated that he does not know what happened, but the date should be checked before the resident signed it. The NOMNC letter should be signed on the 7th of April, 2 days before the resident leaves home or other nursing home. 08/11/2025 12:12 PM, the surveyor interviewed the Director of Nursing (DON). The surveyor notified the DON of the above findings and concerns with Resident#182's NOMNC form. The DON stated that Resident #182 left on 4/9/25 for another nursing home. The DON confirmed that the resident should have a NOMNC done. NJAC 8:39-5.4 (b)(c)

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and review of other facility documentation, the facility failed to ensure the facility was maintained in a safe, clean, and homelike environment. This deficient practice was identified for 2 of 2 units (3rd and 4th floors) and 2 of 2 shower rooms.This deficient practice was evidenced by the following:On 8/13/25 at 9:55 AM, the surveyor with the Housekeeping Director (HD) toured the 3rd floor and observed the following inside the shower room:-Upon entry, toward the right side of the shower room in the 1st cubicle, there was a shower chair with ripped chair cover, and across the 1st cubicle was a plastic tray. The 1st cubicle wall tiles and moldings with yellowish stain. The HD informed the surveyor that the plastic tray was part of a wheelchair that should have not on the floor. The HD confirmed that the tiles should have been cleaned.-The 2nd cubicle floor safety strips were peeling off. The HD stated that the safety strips were safety measures to prevent resident from falling while in shower and should have been fixed. Both the surveyor and the HD observed the ceiling tile with big dried brownish discoloration, tiles stained with yellowish substances, and the ceiling was not totally covered. The HD stated that should have been fixed and floor should be cleaned. -The 4th cubicle safety strips were peeling off, the floor and tiles stained with blackish substances, and no privacy curtain. -The 5th cubicle floor and tiles on the walls stained with blackish substances.-The 6th cubicle safety strips were peeling off. On that same date and time, both the surveyor and the HD observed the soiled utility room with two ceiling tiles with brownish discoloration.On 8/13/25 at 10:10 AM, both the surveyor and HD observed the 4th floor clean linen room with accumulation of grayish substances on the ceiling vent and the HD stated should have been cleaned. At that same time, both the surveyor and the HD observed the 4th floor shower room and observed the following:-The 2nd cubicle privacy curtain with missing hooks.-The 6th cubicle tile walls and floors stained with yellowish substances. On 8/13/25 at 10:15 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) of the 4th floor and the LPN Supervisor (LPNS). The surveyor observed the eyewash area in the nursing station with heavy accumulation of grayish substances and the RN/UM stated that were dust and should have been cleaned. The Assistant Director of Nursing (ADON) donned (put on) gloves and stated she would clean it. Afterward, the surveyor, RN/UM, and LPNS went to the 4th floor panty area, and observed the ceiling vent with heavy accumulation of grayish substances. Both the LPNS and RN/UM stated that should have been cleaned. On 8/13/25 at 10:21 AM, the surveyor with the RN/UM went to the 4th floor dining room and both observed two residents seated near the two vending machines and on top of them was a vent in the ceiling with heavy accumulation of blackish substances. There were total of 10 residents and two facility staff inside the room.Outside the room, the RN/UM stated that the vent should have been cleaned, and she did not know why it was not cleaned. She further stated that she would ask the housekeeper to clean them. The RN/UM informed the surveyor that the two residents were Resident #111 and Resident #30.On 8/13/25 at 1:49 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing (DON), [NAME] President of Clinical Services (VPoCS), and the surveyor notified them of the above observations, concerns, and findings with regard to environment. The VPoCS stated that all those concerns of the surveyor had been addressed after surveyor's inquiry. A review of the facility's Safe and Homelike Environment Policy that was provided by the VPoCS, with implemented date of 9/1/24, revealed under policy: in accordance with resident's rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use their personal belongings to the extent possible. This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Under policy explanation and compliance guidelines .#3. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. 4. The facility will provide and maintain bed and bath linens are clean and in good condition .9. General Considerations: .a. Minimize odors by disposing of soiled linens promptly and reporting lingering odors and bathrooms needing cleaning to Housekeeping Department .A review of the facility's Routine Bathroom/Shower Cleaning Policy that was provided by the VPoCS, with implemented date of 9/1/24, revealed under policy: it is the policy of the facility to establish policies, procedures and guidelines to provide a clean and sanitary environment for residents, staff and visitors in order to prevent cross contamination and transmission of healthcare associated infection.Procedure: 1. Working form clean areas to dirty areas: h. Clean shower/tub faucets, walls and railing, scrubbing as required to remove soap scum. Inspect grout mold, apply disinfectant to interior surfaces of shower/tub, including soap dish, faucets and shower head.Inspect

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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. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to consistently follow standards of clinical practice by following a physician's order for the administration of medications and clarifying a physician's order for 2 of 5 residents (Resident #19 and #21). This deficient practice was 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 and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 8/13/25 at 7:51 AM, the surveyor and the Licensed Practical Nurse/Unit Manager (LPN/UM) observed Resident #19 in bed with the head of the bed flat. The surveyor observed that when the LPN/UM raised the head of the resident's bed, the resident stated, I hurt, I hurt. The LPN/UM replied that she would inform the LPN staff nurse assigned to Resident #19 to administer the resident's tramadol (pain medication). The surveyor reviewed Resident #19's medical record. A review of Resident #19's admission Record reflected the resident was admitted to the facility with diagnoses that included but were not limited to; Alzheimer's Disease, diabetes mellitus, and a stage 4 pressure ulcer (extensive tissue damage that extends into the muscle and bone) of the sacral region (tailbone area). A review of a Physician's Order dated 7/7/25 and transcribed onto the Medication Administration Record (MAR) indicated tramadol hcl 50 milligrams (mg), give one tablet by mouth every 8 hours as needed for moderate to severe pain level of 4-10.; PO dated 2/19/25 for tramadol Hcl 50 mg PO give one time a day before wound care. A review of a Physician's Order dated 7/11/25 and transcribed onto the Treatment Administration Record (TAR) indicated to cleanse the sacral wound every evening and night shift with acetic acid 1%, apply skin prep to the surrounding tissue, pack with calcium alginate, and secure with a bordered foam dressing. A review of the July 2025 MAR revealed the nurses signed for the tramadol from 7/1 through 7/31/25 as given at 9:00 AM, before wound care. (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 August 2025 MAR revealed the nurses signed for the tramadol from 8/1 through 8/13/25, as administered at 9:00 AM, before wound care. A review of the July and August MARs indicated the nurses had not administered the pain medication according to the physician's order before providing the wound treatment during the evening or night shift but had administered it once daily at 9:00 AM. A review of the July TAR revealed that the nurses signed that the treatment was administered during the night shift. A review of the August TAR revealed that the nurses signed from 8/1 through 8/13/25 that the wound treatment was administered during the evening and night shift. A review of the Quarterly MDS, an assessment tool dated 7/31/25, reflected that Resident #19 had a Brief Interview for Mental Status (BIMS) score of 3 out of 15, which indicated severe cognitive impairment. Section M reflected that the resident had one stage 4 unhealed pressure ulcer present on admission. A review of Resident #19's Care Plan revealed a Focus area that included but was not limited to; the resident has an actual pressure ulcer to his/her sacrum. Interventions included to administer medication for pain as needed and reassess; provide a pressure-relieving mattress, provide wound treatment as ordered; weekly wound assessment; and weekly wound skin evaluation by wound team. A review of the Wound Assessment Report dated 6/5/23 (Present on Admission) reflected a wound to the sacrum stage 4; 2.00 centimeters (cm) x 1.20 cm x 3.00 cm (depth) with treatment orders which indicated to cleanse the wound with 0.125% wound cleaning solution, apply skin prep to peri-wound, and use Dakins moistened fluffed gauze bordered with foam daily. A review of the Wound Assessment Report 8/6/25 revealed: stage 4 st sacrum; .7x.7x1.0 cm depth 100% granulation; stable; with orders to cleanse with Acetic Acid 1% pack with Calcium Alginate with silver; cover with bordered foam dressing two times a day. On 8/13/25 at 9:00 AM, during an interview with the surveyor, the regional nurse stated that Resident #19's niece (POA) would not allow the surveyor to observe the resident's sacral wound treatment. On 8/14/25 at 10:00 AM, during an interview with the surveyor, the LPN assigned to resident 19's care confirmed that he should have clarified the 9:00 AM, tramadol order with the physician, as he had not provided the wound treatment on the day shift. On 8/14/25 at 1:15 PM, the surveyor discussed the above observations and concerns with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and [NAME] President of Clinical Services (VPCS). The VPCS acknowledged that Resident #19 should have received their tramadol before the stage 4 wound treatment was provided per the physician's order and confirmed the treatment was being done on the evening and night shifts. The VPCS confirmed that it was the responsibility of the LP/UM to review Physician Orders. (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 facility's policy Following Physician Orders dated 9/1/24 reflected .Medications must be administered in accordance with the orders, including any required time frame . 2. On 8/13/25 at 9:59 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #21. The admission Record (a summary of important information about the resident) documented Resident #21 had diagnoses that included but were not limited to, heart failure, hypertension (high blood pressure), and benign prostatic hyperplasia (enlarged prostate). A comprehensive Minimum Data Set (MDS) assessment, a tool to facilitate the management of care, dated 6/20/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #21 scored a 7 out of 15, which indicated the resident had severe cognitive impairment. A physician's order dated 6/17/25 indicated finasteride 5 milligrams (mg), give 1 tablet by mouth in the afternoon for BPH; Hold if Systolic Blood Pressure (SBP) less than 110, Hold if heart rate (HR) less than 60. A review of the June 2025 Medication Administration Record (MAR) revealed the nurses signed for the finasteride medication from June 19th to June 30 as administered. There was no documentation on the MAR entry of the resident's BP and HR at the time of administration. A review of the July 2025 Medication Administration Record (MAR) revealed the nurses signed for the finasteride medication from July 1st to July 31 as administered. There was no documentation on the MAR entry of the resident's BP and HR at the time of administration. A review of the August 2025 Medication Administration Record (MAR) revealed the nurses signed for the finasteride medication from August 1st to August 12th as administered. There was no documentation on the MAR entry of the resident's BP and HR at the time of administration. On 8/13/2025 at 10:59 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) in the presence of the Assistant Director of Nursing (ADON) about medications with BP and HR parameters. The RN/UM stated the nurses checked the resident's BP at the time the medication was to be administered, and the results would determine whether the nurse held the medication or administered the medication according to the physician's orders. The RN/UM further explained that the nurses documented the BP and HR results in the MAR or in a progress note. The surveyor reviewed with the RN/UM, the finasteride entry on the MAR of Resident #21. The surveyor discussed the concern that there was no documentation of the resident's BP and HR at the time of the medication's administration. The surveyor with the RN/UM reviewed the documented BP and HR in the vitals section of the EMR. The RN/UM confirmed the nurses did not document the BP and HR obtained for every finasteride administration. The RN/UM stated it was expected for the nurses to read the physician's order which included the parameters and they should document the BP and HR results at the time of administration. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/13/2025 at 11:17 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) in the presence of a Registered Nurse (RN) about medications with parameters. The LPN stated it was expected for nurses to follow the physician's orders for medications with parameters. The LPN explained the nurses checked the applicable vital signs at the time of a medication's administration and then documented the results in the MAR entry when prompted. The surveyor asked the LPN what would happen if the entry did not prompt the nurse to enter a result. The LPN replied that a note should be written to include the results obtained at the time of administration to show why the medication was given or not given to the resident. On 8/13/2025 at 11:40 AM, the surveyor interviewed the Director of Nursing (DON) who stated medications with parameters should be followed as per the physician's order. The DON explained the nurses checked the vital signs before administering a resident's medication as per the physician's parameter orders. The DON further stated the nurses documented the results in a drop-down box on the MAR and if they there was no drop-down box, the nurses could add it to the order entry or write a progress note documenting the results. The surveyor with the DON reviewed Resident #21's finasteride order entry in the MAR. The DON stated she would have to review the resident's EMR as this was not a standard for finasteride to have parameters and that it may have been entered in error. The DON stated she would follow up and provide the surveyor with additional information. On 8/13/2025 at 1:49 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the [NAME] President of Clinical Services (VPCS) about the above concern for Resident #21's finasteride order. There was no verbal response at this time by the facility. On 8/14/2025 at 1:06 PM, the LNHA, the DON, and the VPCS informed the survey team Resident #21's finasteride order was clarified with the physician, that there was no need for parameters and the medication should not have had parameters. There was no additional information provided by the facility. The surveyor reviewed the facility provided policy titled, Medication Administration, dated 9/1/2024. Under Policy revealed: . Medications are administered by licensed nurses, or staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The Policy Explanation and Compliance Guidelines of the policy revealed: . 8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.21. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR.23. Correct any discrepancies and report to nurse manager.11. The following information is checked/verified for each resident prior to administering medications .b. Vital signs, if necessary.21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. NJAC 8:39-11.2 (b); 29.2(d)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident receive treatment and care as specified by hospital discharge orders, in accordance with professional standards of practice and facility policies and procedures for 1 of 35 residents (Resident #169) reviewed. The deficient practice was 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 and 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 regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 8/12/2025 at 10:30 AM, the surveyor observed Resident #169 lying in bed. The resident stated that they have been in the facility for 1 year and 5 months. The resident stated that they were in the hospital a few months ago because they could not breathe, and that they called 911. The resident stated that they received liquid antibiotics in the hospital.On 8/12/2025 at 10:39 AM, the surveyor interviewed the License Practical Nurse (LPN) #1, who stated that the resident had a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), a lung condition that obstructs airflow, making it difficult to breathe. The LPN further stated that the resident was sent to the hospital for shortness of breath and returned to the facility with a nebulizer (a small machine that turns liquid medication into a mist so that it can be inhaled). On 8/12/2025 at 12:05 PM, the surveyor reviewed the medical records which revealed diagnoses which included but not limited to COPD with acute exacerbation and other asthma. A review of the physician order summary revealed:-Breo Ellipta Inhalation Aerosol Powder Breath Activated 100-25 MCG/ACT (Fluticasone Furoate Vilanterol) 1 puff inhale orally one time a day for COPD -Order Date 3/20/2025. -Montelukast Sodium Oral Tablet 10 MG (Montelukast Sodium) Give 1 tablet by mouth one time a day for COPD -Order Date 3/20/2025. -Tiotropium Bromide Monohydrate Inhalation Capsule 18 MCG (Tiotropium Bromide Monohydrate) 1 inhalation inhale orally one time a day for COPD -Order Date 3/20/2025. -Albuterol-Budesonide Inhalation Aerosol 90-80 MCG/ACT (Albuterol-Budesonide) 1 puff inhale orally every 6 hours as needed for SOB/ Wheezing -Order Date 3/20/2025. -Ipratropium-Albuterol Solution 0.5- 2.5 (3) MG/3ML 3 ml inhale orally via nebulizer every 4 hours as needed for congestion, sob **Before treatment obtain LS, O2, Respiration **After treatment Obtain LS, O2, Respiration, number of minutes spent completing treatment LS 1=clear 2=diminished 3=crackles 4=wheezes 5=bronchospasms **Rise and spit after each use** -Order Date 5/14/2025. A review of the Quarterly Minimum Data Set (MDS), an assessment tool that facilitates the plan of care, dated 7/2/25, revealed a Brief Interview Mental Status (BIMS) score of 15 out of 15, indicating the resident had intact cognition.A review of a nursing progress note date 3/19/25, revealed Resident #169 had complained of chest congestion and cough. The nurse gave the resident a breathing treatment and cough syrup. The resident called 911 to go to hospital and left against staff nurse and supervisor advise. The Medical Director (MD) was made aware.A review of the Emergency Department (ED) notes dated 3/19/25, revealed the resident complained of chest pain, a cough for 3 days, and had a primary medical history of COPD. A chest x-ray (CXR) was done which revealed no infiltrate (abnormal accumulation of a substance other than air within the lungs). The resident was given nebulizer treatments and steroids (medication used to reduce inflammation). A review of blood work that was drawn revealed unremarkable results. The resident was readmitted back in the facility on 3/20/25.On 8/12/2025 at 1:00 PM, the surveyor requested from the Regional [NAME] President of Clinical Services, any pulmonology consult notes. On 8/13/2025 at 11:24 AM, the surveyor reviewed the residents Emergency Department's discharge instructions dated 3/20/2025, which revealed to follow up with the primary care provider within 2 to 4 days; pulmonary services within 1 month; to contact the office of the lung doctor for post hospital follow up appointment; and follow up Cat Scan (CT)(a medical imaging technique used to obtain detailed internal images of the body) of the chest for July of 2025.A further review of the Nurse Practitioner (NP) notes dated 3/23/25 at 1:30 revealed, the resident called 911 for shortness of

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315331	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Fair Lawn Edge	77 East 43rd Street Paterson, NJ 07514

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to ensure, a.) proper handling and storage of linen and laundry and b.) proper disposal of garbage to prevent the potential spread of infection in accordance with standards of clinical practice, and the facility's policy. This deficient practice was identified for 1 of 1 laundry area, 1 of 3 linen rooms, and 1 of 2 shower rooms observed during infection control tour.This deficient practice was evidenced by the following:On 8/13/25 at 9:38 AM, the surveyor toured the laundry area in the presence of the Laundry Staff (LS). Both the surveyor and the LS observed the following:-Upon entry to the laundry area, there was an electric fan on the floor blowing air toward the clean hung personal clothes of the residents. The electric fan with heavy accumulation of grayish substances and the personal clothes of the residents were uncovered. The LS confirmed that it was accumulation of dust that was in the electric fan and should have been cleaned.-the laundry floor with scattered crumpled papers, candy wrappers, and accumulation of dust. The LS confirmed the observation and stated that the floor did not look like it was mopped last night. The LS further stated that she did not know when the last time was it was mopped.-the laundry folding table for clean clothes with bottled water (halfway full), lunch bag, papers, binder, pens, notebook, roll of plastic bags, hangers, personal bottle container, and a clean sock with room number that was handwritten over a piece of tape. The LS confirmed that there should be no personal stuff on top of clean folding table that was being used for folding the clean clothes of the residents.- there was an electric heater upon entry to the door on the ceiling with heavy accumulation of grayish substances which the LS considered dust and should have been cleaned.- there was a commercial electric fan on the end of the room was blowing air toward the clean unfolded clothes of the residents. The commercial electric fan with accumulation of grayish substances that the LS confirmed dust and should have been cleaned. The LS stated that there was no window in the laundry room and needed the fan, there was a clean residents clothing uncovered near the commercial fan and the LS stated that was contaminated now.On 8/13/25 at 9:48 AM, the surveyor and the Housekeeping Director (HD) went inside the clean linen room, upon entry there was an electric fan with heavy accumulation of grayish substances, blowing air toward the clean folded linens, blankets, towels, and gowns. The linen supplies were uncovered and unbagged. There was a used surgical mask on the floor. The floor with accumulation of dust (grayish substances). There were three ceiling tiles with dried brownish discoloration and below were clean folded fitted sheets uncovered and unbagged.On that same date and time, the HD stated that the brownish discoloration on the ceiling tiles was water condensation. She further stated that fan should have been cleaned, no garbage on the floor, and the clean folded linens were now considered contaminated due to accumulation of dust that were blown to the clean supplies. The HD also stated that the surgical should be properly disposed to the garbage receptacles and not left on the floor.On 8/13/25 at 9:55 AM, the surveyor with the HD toured the 3rd floor shower room and both observed the 2nd cubicle shower there was a wet used washcloth on the floor. The HD stated that it was the CNA who used the washcloth for cleaning the resident and should not be on the floor. The HD acknowledged that the used washcloth should have been properly disposed to the garbage receptacle. On 8/13/25 at 11:05 AM, the surveyor interviewed the Infection Preventionist Nurse/Licensed Practical Nurse (IPN/LPN) in the presence of the Regional Registered Nurse (RRN). The IPN/LPN informed the surveyor that part of her responsibility as an IPN was to do environmental rounds. The surveyor notified the IPN/LPN and the RRN of the above findings and concerns. The IPN/LPN acknowledge the surveyor's concerns. The IPN/LPM and the RRN had no response when asked by the surveyor why the above findings and concerns were not identified if that was part of the IPNs responsibility to do infection control routine tour. On 8/13/25 at 1:49 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), [NAME] President of Clinical Services (VPoCS), and the surveyor notified them of the above observations, concerns and findings with regard to infection control. A review of the facility's Handling Clean Linen Policy that was provided by the VPoCS, with date of implementation of 9/1/24, revealed that it was the facility's policy to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection .Definitions: linen includes sheets, blankets, pillows, towels, washcloths, and similar items from departments such as nursing, dietary, rehabilitative services, beauty shops, and environmental services. contaminated linen is linen that has been soiled with blood or other potentially infectious materials . Policy Explanation and Compliance Guidelines: 2. Linen can become contaminated with pathogens from