PRINTED: 12/13/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315185	B. WING		С
		315165	D. WING _		10/01/2021
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
COMPLET	E CARE AT LINWOOD, L	rc		201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 000	INITIAL COMMENTS		F 0	00	
	Complaint #: NJ1487 NJ145498	02; NJ148041 and			
	Census: 150				
	Sample Size: 14				
	The facility is not in corequirements of 42 Cl Long Term Care Facil complaint survey.	FR Part 483, Subpart B, for			
F 580 SS=E		jury/Decline/Room, etc.))(i)-(iv)(15)	F 5	80	11/8/21
	consult with the reside consistent with his or representative(s) whe	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is-			
		ring the resident which as the potential for requiring ;			
	mental, or psychosoc deterioration in health	ge in the resident's physical, ial status (that is, a ı, mental, or psychosocial reatening conditions or			
	clinical complications (C) A need to alter tre a need to discontinue); eatment significantly (that is, an existing form of			
	treatment due to adve commence a new form (D) A decision to trans				
	resident from the facil §483.15(c)(1)(ii).	ity as specified in			
	(14)(i) of this section,	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2)			
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u> :	TITLE	(X6) DATE

Electronically Signed 10/28/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			, a Boile	_		، ا	2	
		315185	B. WING			10/01/2021		
NAME OF PI	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		01/2021	
				2	201 NEW ROAD AND CENTRAL AVE			
COMPLET	E CARE AT LINWOOD, I	LLC		L	LINWOOD, NJ 08221			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREF	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	(X5) COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	ATE	DATE	
F 580	Continued From page	e 1	F	580				
	is available and provi	ded upon request to the						
	physician.							
		also promptly notify the						
		dent representative, if any,						
	when there is-							
		or roommate assignment						
	as specified in §483.10(e)(6); or							
		ent rights under Federal or						
		ns as specified in paragraph						
	(e)(10) of this section	record and periodically						
		mailing and email) and						
	phone number of the	,						
	representative(s).	resident						
	§483.10(g)(15)							
		osite distinct part. A facility						
		istinct part (as defined in						
		e in its admission agreement tion, including the various						
		se the composite distinct						
		y the policies that apply to						
	-	en its different locations						
	under §483.15(c)(9).							
		「 is not met as evidenced						
	by:							
	Complaint Intake NJ	145498			COMPLETE CARE AT LINWOOD			
					PLAN OF CORRECTION			
		ews, interviews, and facility			This plan of correction constitutes our			
		determined the facility failed			written allegation of compliance for the			
		s' physician of a potential			deficiencies cited. However, submissio	n		
		fically, the facility failed to			of this plan of correction is not an	,		
	notify the physician o				admission that a deficiency exists or the	at		
		e physician when doses of a			one was cited correctly. This plan of			
		cation was missed for one			correction is submitted to meet			
	, ,	residents reviewed for			requirements established by state and federal law.			
	_	and failed to ensure the ctor and/or the resident's			F580: SS = E - Notify of Changes			
	_	vere notified of medication			(Injury/Decline/Room, etc.) CFR(s):			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245495	B. WING		С
NAME OF D	ROVIDER OR SUPPLIER	315185	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	10/01/2021
NAIVIE OF PI	ROVIDER OR SUPPLIER			201 NEW ROAD AND CENTRAL AVE	
COMPLET	E CARE AT LINWOOD, I	LLC		LINWOOD, NJ 08221	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 580	#10, and #11) of 10 remedication errors. This failure had the presidents who lived of unit. Findings included: 1. Review of the physician orders indicated with diagram of the physician orders indicated for the resident #2 with diagram of the resident record diagram of the physician orders indicated for the physician orders in the physician orders in the physician of the physician orders in the physician order of the physician o	computerized cated the facility admitted gnoses that included with a Brief Status (BIMS) score of equired one-person physical mobility, transfer, walking, and personal hygiene. The istance with setup to eat. #2's hospital discharge revealed tablets by mouth two times was listed as part of ician wanted Resident #2 to charge.	F 58	483.10(g)(14)(i) -(iv)(15) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED THE DEFICIENT PRACTICE: ¿ Resident #2 was no longer in the facility (discharged Against Medical Advice) when the deficient practice videntified. ¿ The facility's Medical Director ar residents' respective attending physi were notified of the medication errors Residents #4, #5, #6, #7, #8, #9, #10 #11. No actual harm was identified in of the residents due to the missed do in-serviced regarding facility's policy regarding notifying the Attending Physicians and/or Medical Director of potential health hazard, including posallergies and medication errors. II. IDENTIFICATION OF RESIDEN WHO HAVE THE POTENTIAL TO BIAFFECTED BY THE SAME DEFICIE PRACTICE	o BY e vas d the cians s for d, and n any sees. d and f any sible TS E ENT it had me d the n the e of cally and to
	A review of the nursir	ng note charted on		F. 35855.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	315185	B. WING			C 10/01	1/2021
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	'	10/0	1/2021
			201 NEW ROAD AND CENTRAL AVE			
COMPLETE CARE AT LINWOOI), LLC		LINWOOD, NJ 08221			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
Nurse (LPN) #1 ind medical record idea for the ordered what the war in the MAR that the the record did not in Resident #2's atternedical director to and get clarification administered to Redocumented on the the medication to F9:00 AM, although indicate any adversing the ordered administration there a rationale which domedication was not reaction was not reactio	PM by Licensed Practical dicated that the electronic intified a possible drug. The record did not report as. Although LPN #1 recorded a medication was administered, indicate whether LPN #1 called adding physician or the facility's discuss the triggered in before the medication was assident #2. LPN #12 also as MAR that she administered at the medical record did not asses effect from Resident #2 at the medical record did not indicate as effect from Resident #2 at the medication, or the eof. The record did not indicate as bypassed. If you on 09/30/2021 at 12:34 PM, (RN) #1 stated she was the Resident #2. She stated when the did to the facility on itented the resident to the did went back to the nurses' resident's medications on the record. Per RN #1, she called all director (MD), who was also anding physician, do a liation through the list of the prescribed to Resident #2 arge. RN #1 stated that she attonale for not administering terring to the	F 58	III. MEASURES PUT INTO PI SYSTEMIC CHANGES TO EN THAT THE DEFICIENT PRACT NOT RECUR: ¿ All Nurses were in-serviced the facility's Policy regarding not Attending Physicians and/or Moderation of any potential health specifically possible allergies a medication errors, including misdoses. IV. MONITORING OF CORREACTIONS: ¿ Unit Manager/Designee wit weekly Record Review audits of	SURE TICE WII d regard otifying the edical hazards nd/or an ssed ECTIVE ill conduct of 5) per wee onthly x 6 entifying the hazard g missed to ical l be liately. o the strator at the tAPI need for	LL ling he s, ly ct ek s the ds, d	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		315185	B. WING		10	C 0/01/2021
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		701/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 580	daily for the medication the resident admitted that Resident #2 only medication in the more dose in the morning of concluded that Resided doses of the medication been given on the evanother that should have been given on the resident and the facility prior knowledge of the Don stated that record triggered an pharmacist identified the nursing staff were identified concern to Don stated that the I order to hold and man another medication the functions as the one failure to administer a resident and administriggered as an properly documenting medication both pose resident. During an interview of the MD verified that he more failured that he more fa	ordered doses of twice because in the evening. She verified got a dose of the raing on and a lend	F 58	80		
		cations for every newly signed to him. Per the MD,				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		315185	B. WING _		_	C 10/01/2021	
NAME OF PROVIDER OR COMPLETE CARE AT		LLC	1	STREET ADDRESS, CITY, ST 201 NEW ROAD AND CEN LINWOOD, NJ 08221		10/01/2021	
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		
the facilit hospital k changes. situation that the control the facilit medication who was on the wa	out would so The MD sta with Reside only reason I y continued on to Reside as as simple as as simple to the side on the side as as simple to the s	owed the orders from the metimes make necessary ated he did not recall the nt #2 specifically. He stated ne would have approved that to administer the questioned ont #2 was if the reported	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	315185	B. WING		C 10/01/2021	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	10/01/2021	
COMPLETE CARE AT LINWOOD,	LLC	I	201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
administered to the response of the response o	ligram (mg) t bedtime for one in a day for mg one capsule by mouth two olet mg tablets by mouth at bedtime mg, one tablet by mouth at tablet 1 mg, four edtime related to . mg/milliliter (ml) ml by mouth two times gram (gm) ml, give es a day for one in tablet mg, one tablet by one in tablet mg, one tablet by . one in tablet mg, one tablet mg, one tablet by . one in tablet mg, one tablet mg	F 580			

	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT LINWOOD, LLC STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221 DPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE			315185	B. WING			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE TAG DEFICIENCY			LLC		201 NEW ROAD AND CENTRAL AVE	10/01/2021	
F 580 Continued From page 7 F 580	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOODS). CROSS-REFERENCED TO THE APP	OULD BE COMPLÉTIO	ON
Review of the Medication Administration Record (MAR) for indicated the following ordered medications were not initialed as being administered to the resident on at the second at the se	F 580	Review of the Medica (MAR) for ordered medications administered to the response one needed for tablet by mouth three microgram (mcg)/actreach at bedtime tablet at bedtime tablet at bedtime tablet mouth at bedtime for tablet mouth at bedtime for tablet must be tablet mouth at bedtime for tablet mouth at bedtime for tablet must be tablet mouth at bedtime for tablet mouth at bedtime for tablet mouth at bedtime for tablet must be tablet must	ation Administration Record indicated the following were not initialed as being esident on at at at a milligrams (mg), every 24 hours as a day related to gram (gm) milliliter (ml) all by mouth two times a day suspension at in the for ablet mg, give one tablet hours related to gram, give one tablet hours related to type. In the for a mg, give one tablet hours related to type. In the for a mg, give one tablet hours related to type. In the for a mg, give one tablet hours related to type. In the for a mg, give one tablet hours related to type. In the for a mg, give one tablet hours related to type. In the for a mg, give one tablet hours related to type. In the for a mg, give one tablet by mg, give one tablet by mg, give one tablet by mouth at the forth mg, one tablet by mouth at the forth mg, one tablet by mouth at the following tablet by millimiter (ml) at the following tablet by make the following tablet by mouth at the following tablet by make the fol	F 5	80		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
		315185	B. WING _			C 10/01/2021		
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		10/01/2021		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 580	three times a day for 4. Review of the physician orders indirectly resident #6 with diagrams and the resident #6 with diagrams administered to the resident material to th	computerized cated the facility admitted gnoses that included and and and and and and and and and an	F5	580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		ATE SURVEY DMPLETED	
		315185	B. WING _			C 10/01/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		10/01/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From page	e 9 and other	F	580			
	(MAR) for ordered medications administered to the region PM: - miles a day or stablet mone tablet by mouth the capsule mouth every eight hore tablet mouth every eight hore tablet mouth every eight or tablet times a day for stablet stablet times a day for stablet	lligram (mg), two tablets y for computerized cated the facility admitted					
	(MAR) for	indicated the following were not initialed as being esident on at milligram (mg), one tablet					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315185	B. WING _			C 10/01/2021		
	ROVIDER OR SUPPLIER	, LLC			, CITY, STATE, ZIP CODE IND CENTRAL AVE 08221	1 10/01	72021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD -REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 580	tablet bedtime for tablet bedtime for mouth two times a commouth three times a 7. Review of the physician orders incommouth #9 with diameters. Review of the Medic (MAR) for	mg, one tablet by mouth at mg, one tablet orally at tablet by day for tablet mg, one tablet by day for computerized dicated the facility admitted agnoses that included with with cation Administration Record indicated the following sewere not initialed as being	F	580				
	by mouth at bedtime mg/milliliter (ml), four hours as neede mouth at bedtime for ml by mouth for tablet mouth at bedtime for orally via) solution give ml by mouth every ed for tablet mg, one tablet by or ur times a day for mg), two tablet by						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		315185	B. WING _			C 10/01/2021	
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		10/01/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 580	two times a day for capsule mouth three times a day for capsule mouth three times a day for capsule mouth three times a day for some capsule and the following capsule capsule and the following capsule c	mg, one tablet by mouth mg, one capsule by day for computerized cated the facility admitted agnoses that included ation Administration Record indicated the following were not initialed as being esident on at bedtime for microgram (mg) at bedtime for computerized cated the facility admitted agnoses that included	F 5	580			
	(MAR) for	ation Administration Record indicated the following were not initialed as being					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	СОМ	E SURVEY PLETED
		315185	B. WING			C
	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	10	/01/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 580	administered to the region PM: - tablet mill one tablet by mouth the tablet, give a day for times a day for times a day for tablet tablet mouth at bedtime for tablet at bedtime related to due to know the nursing home adricopies of the facility's to administer medicate residents. The investivitien statement by I (LPN) #3. The date an incident/accident portice as statement read, "I coupass for the second of to the fact I was over behaviors, exit seeking (everywhere)." The Dincluded in the investions.	igram (mg) wo times a day for mg by mouth three times . mg one capsule by mouth three /milliliter (ml) as . mg /ml, at bedtime for . mg, give tablet by mouth with vn . n 09/30/2021 at 2:57 PM, ninistrator (NHA) provided investigation into the failure ion to the identified gation report included a .icensed Practical Nurse nd time of the ion of the statement was -9PM med pass." The uld not complete the med art during the 3-11 shift due whelmed dealing with severe g and fall risk isciplinary Action form gation indicated the facility on as a safety violation and	F 58			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	DING			(X3) DATE SURVEY COMPLETED	
		315185	B. WING _				C 01/2021	
	ROVIDER OR SUPPLIER	TC	1	STREET ADDRESS, CITY, STATE, ZIP CO 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	DDE	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE	
F 580	Detailed Description of form read, "Group II vanot up to professional alert supervisor that ron cart one on south portion of the form resuspended on a start date of the facility reports board. Although there was not identified residents had the facility assess that the facility assess that they did not have the missed medication. LPN #3 was said to have the missed medication was not available for Unsuccessful attempt #3 on 09/30/2021 at a 20 During an interview of LPN #1 stated that it allergies before admiresidents to prevent a stated that if she encoduring med pass, she the Director of Nursin the MAF identified residents not administered their during the 9:00 PM milack of nurse's initial. administer medication medication error.	of Offense Portion of the violation - Work performance I standard. Nurse did not med pass was not completed unit." The Action Taken wealed LPN #3 was date of and and end the record did not indicate ed LPN #3's action to the oreported decline in the ealth related to the missed and however, did not indicate sed the residents to ensure any ill effects resulting from ms. ave gone on vacation and interview during the survey. It was made to contact LPN #1:10 PM. In 10/01/2021 at 10:56 AM, was important to check for instering medication to the an adverse reaction. LPN #1 pountered any challenges a notified the unit manager or g (DON). LPN #1 reviewed R and verified that the oted above were not	F	580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315185	B. WING		C 10/01/2021
	ROVIDER OR SUPPLIER	щс		STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	1 1010 11202
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 580	residents did not get evidenced by lack of failure to administer medication to a reside medication error. On 10/01/2021 at 1: DON were interview not employed with the said incident, and not DON, however, clarificident report relates the basis for why the their 9:00 PM medic DON, the synopsis of LPN #3, who was the unit, failed (med) pass with the the shift supervisor.	MAR of the and acknowledged the their 9:00 PM medication as fourse's initial. Per LPN #2, a physician ordered dent was considered a dent was considered a dent was considered a dent was the NHA and the ed. The NHA stated she was ne facility at the time of the either was the DON. The fied that she reviewed the ed to the event which formed exidentified residents missed ations on the latter of the incident report revealed the nurse assigned to the to complete medication residents and failed to notify Per the DON, if LPN #3 had	F 58	,	
	would have been se completing the med important to administ avoid medication or missed medication of wellbeing. The DON concern for the resident where unable to DON stated that who occurred, the facility notified the Medical resident/resident's red DON stated that after resident would have adverse effect from stated that if an adverse that if an adverse complete important to administration of the medical resident would have adverse effect from stated that if an adverse important to administration of the medical resident would have adverse effect from stated that if an adverse important to administration of the medical resident would have adverse in the medical resident would have a medical resident would have	or of her concern, a nurse on to the unit to assist with pass. She stated that it was over the DON stated that could affect the residents' stated there was a safety dents on the affected unit as verbalize their concern. The en a medication error identified the error and Director (MD) and the esponsible party (RRP). The err any medication error, the been monitored for any the said error. The DON erse effect were noted, the dan order was received			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		315185	B. WING		C 10/01/2021
	ROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	10/01/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580	facility kept the RRP on with the resident of the DON acknowled documentation in the monitoring of the ider MD or RRP were not acknowledged that LI reported to the board. During an interview of the MD stated that he group of residents as their medications on On 09/30/2021 at 2:5 copy of the policy title Medications" updated If a dosage is belie excessive for a reside been identified as has consequences for the being associated with person preparing or a shall contact the resident.	would be to send the al. The DON stated that the apprised on what was going ntil the resident recovered. ged there was no record which captured the ntified residents or that the fied. The DON PN #3's action was not In 10/01/2021 at 1:43 PM, was not made aware that a identified above missed at 9:00 PM.	F 58		
F 760 SS=E	Residents are Free of CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Resident medication errors.	nts are free of any significant	F 76	60	11/8/21
	This REQUIREMENT by:	is not met as evidenced			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		315185	B. WING _	B. WING		C 10/01/2021		
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		-	
COMPLET	E CARE AT LINWOOD, I	10		20	1 NEW ROAD AND CENTRAL AVE			
COMPLET	E CARE AT LINWOOD, I	LLC		LII	NWOOD, NJ 08221			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 760	Continued From page		F7	760	COMPLETE CARE AT LINWOOD			
	Based on record revier policy review, it was confailed to ensure residents in the significant medication #4, #5, #6, #7, #8, #9 residents reviewed for Specifically, the facility residents received the This failure had the pure identity who lived out dementia unit. Findings included: 1. Review of the	ews, interviews, and facility determined that the facility ents were free from as errors for eight (Residents , #10, and #11) of 10 r medication errors. Sy failed to ensure the eir 9:00 PM medications. Otential to affect all 20 in the back hall of the computerized cated the facility admitted			PLAN OF CORRECTION This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submissio of this plan of correction is not an admission that a deficiency exists or the one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. F760: SS=E Residents are Free of Significant Med Errors CFR(s): 483.456 (2) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED FOR THE DEFICIENT PRACTICE: ¿ Disciplinary action was given to the involved LPN, regarding the identified medication errors. LPN was also counseled and re-educate regarding the facility's policy regarding Medication Errors, focusing on promptile.	n at (f) BY e		
	(MAR) for ordered medications administered to the re 9:00 PM:	ligram (mg) t bedtime for one in			communicating to the Unit Manager and/or Supervisor any issues that may potentially result to medication errors. The facility's Medical Director and residents' respective attending physicia were notified of the medication errors for Residents #4, #5, #6, #7, #8, #9, #10, a #11. No actual harm was identified in a of the residents due to the missed dose II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIEN PRACTICE	the ans or and any es.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7.1. 50.25.			С		
		315185	B. WING			10/	01/2021	
	ROVIDER OR SUPPLIER TE CARE AT LINWOOD, I	LLC		20	TREET ADDRESS, CITY, STATE, ZIP CODE 11 NEW ROAD AND CENTRAL AVE INWOOD, NJ 08221			
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F 760	times a day related to tab give two for tablet bedtime for tablets by mouth at be give a day related to other at bedtime for at bedtime for muth at bedtime for mouth at bedtime 2. Review of the physician orders indic Resident #5 with diag	mg one capsule by mouth two plet mg tablets by mouth at bedtime mg, one tablet by mouth at	F	760	¿ All residents in the back hall of the dementia unit have the potential of gett affected by the same deficient practice. The MARs (Medication Administration Records) of these residents were immediately audited for medication error and no other medication errors were found. III. MEASURES PUT INTO PLACE O SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WI NOT RECUR: ¿ All nurses were in-serviced on the Facility's Policy regarding Medication Errors, focusing on promptly communicating any issues that may potentially result to medication errors to the Unit Manager and/or Supervisor. T is to help prevent significant medication errors from occurring. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Unit Manager or designee will reviethe MARs of the residents in the of the Unit to identify any medication errors, specifically missed doses. This will be done weekly x 4 weeks; then monthly thereafter x 6 months. Any identified issues will be addressed immediately. ¿ Findings will be reported to the Director of Nursing and Administrator monthly and presented in the QAPI Meeting quarterly. The QAPI Committe will determine the need for further audit and/or action plans on a quarterly basis	ing . ors R LL orinis		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP C 201 NEW ROAD AND CENTRAL AVE	ODE	10/01/2021	
COMPLET	E CARE AT LINWOOD, I	LLC		LINWOOD, NJ 08221			
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F 760	administered to the response one needed for tablet by mouth three at bedtime at bedtime at ablet mouth at bedtime for tablet mouth at bedtime related to make three times a day for 3. Review of the	indicated the following were not initialed as being esident on at at a milligrams (mg), every 24 hours as a day related to gram (gm) milliliter (ml) I by mouth two times a day related to gram (act.), one in e for a day in the form of	F7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	COVIDER OR SUPPLIER E CARE AT LINWOOD, I			STREET ADDRESS, CITY, STATE, ZIP CO 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		10/01/2021	
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F 760	(MAR) for ordered medications of administered to the response of the property of the physician orders indicated to the physician orders in the p	tion Administration Record indicated the following were not initialed as being esident on at milligram (mg), one very 48 hours as needed for mg, give one tablet orally mg, give one tablet by mouth mg/milliliter (ml) ml by mouth two times mg, one tablet orally at mg, one tablet orally at computerized eated the facility admitted noses that included and millimited indicated the following were not initialed as being	F7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
		315185	B. WING _			C 10/01/2021	
	ROVIDER OR SUPPLIER	TC		STREET ADDRESS, CITY, STATE 201 NEW ROAD AND CENTRA LINWOOD, NJ 08221	,	10/01/2021	
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F 760	one tablet by mouth to a capsule mouth every eight ho three times a day for by mouth every eight tablet times a day for tablet times a day for 5. Review of the	(mg), two tablets of for computerized cated the facility admitted	F7	760			
	(MAR) for ordered medications administered to the region PM: 1	milligram (mg), one tablet mg, one tablet by mouth at mg, one tablet orally at mblet mg, tablet by y for ablet mg, one tablet by					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	.	10/01/2021	
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F 760	physician orders indiced Resident #9 with diagonal and	atted the facility admitted gnoses that included ;; ation Administration Record indicated the following were not initialed as being esident on at at at a milligram (mg), one tablet for a large in a solution at a milligram (mg), one tablet for a large in a solution at a milligram (mg), one tablet by in a mg/ml, a mls two times a day for a mg, one tablet by mouth a mg, one tablet by mouth and mg, one capsule by day for a mg mg, one capsule by day for make the facility admitted as being at a milligram (mg), and tablet by mouth a mg, one capsule by day for mg, and a milligram (mg), and a m	F7	760			
		computerized cated the facility admitted agnoses that included					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	ODE	0/01/2021	
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F 760		e 22 . ation Administration Record indicated the following	F 7	760			
	,	were not initialed as being					
	one tablet by mouth a	at bedtime for microgram					
	(mcg)/actuation (act) in), two at bedtime for					
		computerized cated the facility admitted gnoses that included					
	(MAR) for	indicated the following were not initialed as being esident on					
	one tablet by mouth t - tablet, give a day for -	ligram (mg) (), wo times a day for mg by mouth three times . mg one capsule by mouth three					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	' '	(X3) DATE SURVEY COMPLETED	
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		315185	B. WING _			10/01/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE		
COMPLE	TE CARE AT LINWOOD, I	_LC		201 NEW ROAD AND CENTRAL AVE	Ē		
	,			LINWOOD, NJ 08221			
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F 760	times a day for	/milliliter (ml) as mg), two tablets by . /ml, inject at bedtime for mg, give tablet by mouth n 09/30/2021 at 2:57 PM, ministrator (NHA) provided investigation into the failure ion to the identified gation report included a Licensed Practical Nurse and time of the ion of the statement was -9PM med pass." The all not complete the med art during the 3-11 shift due whelmed dealing with severe ag and fall risk isciplinary Action form igation indicated the facility on as a safety violation and ssional conduct. The of Offense Portion of the riolation - Work performance I standard. Nurse did not med pass was not completed unit." The Action Taken wealed LPN #3 was	F	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		315185	B. WING _			C 10/01/2021	
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CO 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	DDE		
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F 760	board. Although there was ridentified residents! I medications, the received that the facility assess that they did not have the missed medication. LPN #3 was said to was not available for Unsuccessful attemp #3 on 09/30/2021 at. During an interview of LPN #1 stated that if challenges during manager or the Direce #1 reviewed the that the identified residential administer defication error. During an interview of LPN #2 reviewed the identified residents are residents did not get evidenced by lack of failure to administer medication to a residential medication error. On 10/01/2021 at 1:: DON were interviewed to employed with the identified with the identified residents are residents did not get evidenced by lack of failure to administer medication to a residential medication error.	no reported decline in the health related to the missed ord however, did not indicate seed the residents to ensure e any ill effects resulting from ons. The area gone on vacation and interview during the survey. It was made to contact LPN 4:10 PM. The area of Nursing (DON). LPN MAR and verified sidents noted above were not the medication on med pass as evidenced by LPN #1 stated that failure to an per physician order was a murse's initial. Per LPN #2,	F7	760			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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		315185	B. WING			10/	01/2021	
NAME OF P	ROVIDER OR SUPPLIER	•	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				20	01 NEW ROAD AND CENTRAL AVE			
COMPLET	E CARE AT LINWOOD,	LLC		L	LINWOOD, NJ 08221			
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F 760	incident report related the basis for why the their 9:00 PM medicated DON, the synopsis of LPN #3, who was the dementia unit, failed (med) pass with their the shift supervisor. Finformed a supervisor would have been ser completing the med primportant to administ avoid medication error missed medication error missed medication error wellbeing. The DON concern for the resident they were unable to withe DON, the standard complete on the spot error occurred with the rounds. The DON standard was first to prevent moccurring by training precautions of medication error octubred they worked the floor a medication error octubred and the resident/resident (RRP). The DON standard the resident adverse effect from the stated that if an adverse that if an adverse resident to the hospit facility kept the RRP on with the resident to	ited that she reviewed the d to the event which formed identified residents missed ations on Per the f the incident report revealed a nurse assigned to the to complete medication residents and failed to notify Per the DON, if LPN #3 had or of her concern, a nurse at to the unit to assist with coass. She stated that it was been medications as ordered to cor. The DON stated that could affect the residents' stated there was a safety ents on the affected unit as everbalize their concern. Per and process would be to a training when a medication are nursing staff during her atted the facility's process medication error from nursing staff on the ation administration before attended the Medical Director (MD) dent's responsible party the standard process would be monitored for any the said error. The DON state of the lan order was received	F	760				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT LINWOOD, LLC				STREET ADDRESS, CITY, STATE, ZIP COD 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		10/01/2021	
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F 760	caused harm to a resistate Health Departmacknowledged there were cord which captured identified residents or notified. The DON action was not reported action was not reported. During an interview of the MD stated that he group of residents as their medications on On 09/30/2021 at 2:5 copy of the policy title Medications" updated in part, "Medications safe and timely mann Medications must b (1) hour of their presons pecified"	ident was reported to the lent. The DON was no documentation in the did the monitoring of the that the MD or RRP were knowledged that LPN #3's led to the board. In 10/01/2021 at 1:43 PM, was not made aware that a identified above missed at 9:00 PM. If PM the NHA provided a led, "Administering 10/2019. The policy reads shall be administered in a	F 7	60			