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 _____	C 10/01/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ148702; NJ148041 and NJ145498 Census: 150 Sample Size: 14 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		11/8/21

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

Electronically Signed | 10/28/2021

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Complaint Intake NJ145498 Based on record reviews, interviews, and facility policy review, it was determined the facility failed to notify the residents' physician of a potential health hazard. Specifically, the facility failed to notify the physician of a medication [redacted] and failed to notify the physician when doses of a [redacted] medication was missed for one (Resident #2) of four residents reviewed for medication regimen; and failed to ensure the facility's medical director and/or the resident's attending physician were notified of medication	F 580	COMPLETE CARE AT LINWOOD PLAN OF CORRECTION This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. F580: SS = E - Notify of Changes (Injury/Decline/Room, etc.) CFR(s):	

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F 580	Continued From page 2 errors for eight (Residents #4, #5, #6, #7, #8, #9, #10, and #11) of 10 residents reviewed for medication errors. This failure had the potential to affect [redacted] residents who lived on the [redacted] of the [redacted] unit. Findings included: 1. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #2 with diagnoses that included [redacted]. The discharge Minimum Data Set (MDS), dated [redacted] 1, indicated the resident was [redacted] with a Brief Interview for Mental Status (BIMS) score of [redacted] The resident required one-person physical assistance with bed mobility, transfer, walking, dressing, toilet use, and personal hygiene. The resident required assistance with setup to eat. A review of Resident #2's hospital discharge record dated [redacted] revealed [redacted] give 2 tablets by mouth two times a day for [redacted] was listed as part of medications the physician wanted Resident #2 to start taking upon discharge. A review of Resident #2's medication administration record (MAR) from [redacted] through [redacted] (day of discharge) revealed the resident only received the medication once on [redacted] at 5:00 PM and once on [redacted] at 9:00 AM. A review of the nursing note charted on	F 580	483.10(g)(14)(i) -(iv)(15) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Resident #2 was no longer in the facility (discharged Against Medical Advice) when the deficient practice was identified. ¿ The facility's Medical Director and the residents' respective attending physicians were notified of the medication errors for Residents #4, #5, #6, #7, #8, #9, #10, and #11. No actual harm was identified in any of the residents due to the missed doses. ¿ Nurses involved were counseled and in-serviced regarding facility's policy regarding notifying the Attending Physicians and/or Medical Director of any potential health hazard, including possible allergies and medication errors. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents in the [redacted] Unit had the potential to be affected by the same deficient practice. ¿ Unit Manager/Designee reviewed the MARs and records of the residents in the [redacted] unit to identify the presence of any potential health hazards, specifically for missed [redacted] and any medication errors (including missed doses). NO other residents were found to have been affected by the same deficient practice.	

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F 580	Continued From page 3 [redacted] at 1:11 PM by Licensed Practical Nurse (LPN) #1 indicated that the electronic medical record identified a possible drug [redacted] for the ordered [redacted] The record did not report what the [redacted] was. Although LPN #1 recorded in the MAR that the medication was administered, the record did not indicate whether LPN #1 called Resident #2's attending physician or the facility's medical director to discuss the triggered [redacted] and get clarification before the medication was administered to Resident #2. LPN #12 also documented on the MAR that she administered the medication to Resident #2 on [redacted] at 9:00 AM, although the medical record did not indicate any adverse effect from Resident #2 missing the ordered medication, or the administration thereof. The record did not indicate a rationale which detailed the reason the medication was not given and why the triggered [redacted] reaction was bypassed. During an interview on 09/30/2021 at 12:34 PM, Registered Nurse (RN) #1 stated she was the admitting nurse for Resident #2. She stated when Resident #2 admitted to the facility on [redacted], she oriented the resident to the resident's room and went back to the nurses' station to input the resident's medications on the electronic medical record. Per RN #1, she called the facility's medical director (MD), who was also Resident #2's attending physician, do a medication reconciliation through the list of medications that were prescribed to Resident #2 post-hospital discharge. RN #1 stated that she did not recall the rationale for not administering the medication (referring to the [redacted] to the resident on the evening of [redacted] after completing the medication reconciliation with the MD. RN #1 clarified that Resident #2 would not	F 580	III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All Nurses were in-serviced regarding the facility's Policy regarding notifying the Attending Physicians and/or Medical Director of any potential health hazards, specifically possible allergies and/or any medication errors, including missed doses. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Unit Manager/Designee will conduct weekly Record Review audits of 5 residents in the [redacted] Unit) per week x 1 month, then 5 residents monthly x 6 months. Audit will focus on identifying the presence of any potential health hazards, specifically for missed [redacted] and any medication errors (including missed doses) and prompt notification to Attending Physicians and Medical Director. Negative findings will be addressed and rectified immediately. ¿ Findings will be reported to the Director of Nursing and Administrator monthly and will be presented at the quarterly QAPI Meeting. The QAPI Committee will determine the need for further audits and/or action plans on a quarterly basis.	

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have received the two ordered doses of twice daily for the medication on [redacted] because the resident admitted in the evening. She verified that Resident #2 only got a dose of the medication in the morning on [redacted] and a dose in the morning on [redacted]. RN #1 concluded that Resident #2 only missed two doses of the medication (one that should have been given on the evening of admission and another that should have been given at night on [redacted]). RN #1 stated that Resident #2 missed what could have been counted as the third dose when the resident left against medical advice (AMA).

During an interview on 10/01/2021 at 1:17 PM, the Director of Nursing (DON) stated she was not employed at the facility in [redacted] and had no prior knowledge of the situation with Resident #2. The DON stated that when the electronic medical record triggered an [redacted] or either the nurse or pharmacist identified a [redacted] for a resident, the nursing staff were to call and bring the identified concern to the attention of the MD. The DON stated that the MD would typically give an order to hold and make a recommendation for another medication that performed similar functions as the one held. The DON stated that failure to administer a prescribed medication to a resident and administering a medication that was triggered as an [redacted] to a resident without properly documenting the rationale for giving the medication both posed safety concerns to the resident.

During an interview on 10/01/2021 at 1:43 PM, the MD verified that he reviewed the post-hospital discharge list of medications for every newly admitted resident assigned to him. Per the MD,

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the facility mostly followed the orders from the hospital but would sometimes make necessary changes. The MD stated he did not recall the situation with Resident #2 specifically. He stated that the only reason he would have approved that the facility continued to administer the questioned medication to Resident #2 was if the reported [redacted] was as simple as [redacted]. Per the MD, every drug had a side effect, and the benefit of using a medication must outweigh the side effect. The MD stated that he was onsite to see newly admitted residents assigned to him within 48 hours of their admission at the facility, and it was the period he used to reconcile the resident's medication. He stated that Resident #2 had left the facility AMA when he came and as such, he did not have the opportunity to comprehensively review the resident. The MD concluded that without documentation to support the decision to give or hold the medication at the time relevant to the complaint, he could not speak to whether the facility clarified the order with him and what his recommendation was at the time.

2. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #4 with diagnoses that included [redacted]

Review of the Medication Administration Record (MAR) for [redacted] indicated the following

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F 580	Continued From page 6 ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] tablet [redacted] milligram (mg) [redacted] mg tablet by mouth at bedtime for [redacted]. - [redacted] one [redacted] in both [redacted] two times a day for [redacted]. - [redacted] mg [redacted]), one capsule by mouth two times a day related to [redacted] - [redacted] tablet [redacted] mg ([redacted]), give two tablets by mouth at bedtime for [redacted] tablet [redacted] mg, one tablet by mouth at bedtime for [redacted]. - [redacted] tablet 1 mg, four tablets by mouth at bedtime related to [redacted]. - [redacted] mg/milliliter (ml) [redacted], give [redacted] ml by mouth two times a day related to other [redacted] - [redacted] gram (gm) [redacted] ml, give [redacted] ml by mouth two times a day for [redacted] - [redacted] one [redacted] in [redacted] at bedtime for [redacted] - [redacted] tablet [redacted] mg, one tablet by mouth at bedtime for [redacted]. - [redacted] tablet [redacted] mg [redacted]), two tablets by mouth at bedtime related to [redacted] 3. Review of the [redacted] computerized physician orders indicated the facility readmitted Resident #5 with diagnoses that included [redacted]	F 580		

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[redacted].

Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM:

- [redacted] milligrams (mg), [redacted] one [redacted] every 24 hours as needed for [redacted].
- [redacted] tablet [redacted] mg, give one tablet by mouth three times a day related to [redacted].
- [redacted] gram (gm) [redacted] milliliter (ml) [redacted], give [redacted] ml by mouth two times a day for [redacted]
- [redacted] suspension [redacted] microgram (mcg)/actuation (act.), one [redacted] in each [redacted] at bedtime for [redacted].
- [redacted] tablet [redacted] mg ([redacted]), give one tablet at bedtime for [redacted].
- [redacted] tablet [redacted] mg, give one tablet by mouth every eight hours related to [redacted] type.
- [redacted] tablet [redacted] mg, give one tablet by mouth at bedtime for [redacted].
- [redacted] tablet [redacted] mg by mouth at bedtime for [redacted].
- [redacted] tablet [redacted] mg, one tablet by mouth at bedtime related to [redacted].
- [redacted] mg tablet, give two tablets orally

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F 580	Continued From page 8 three times a day for [redacted] management. 4. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #6 with diagnoses that included [redacted] and Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] milligram (mg), one [redacted] every 48 hours as needed for [redacted]. - [redacted] tablet [redacted] mg, give one tablet orally one time a day for [redacted]. - [redacted] tablet [redacted] mg, give one tablet by mouth one time a day for [redacted]. - [redacted] mg/milliliter (ml) ([redacted], give [redacted] ml by mouth two times a day for [redacted]. - [redacted] tablet [redacted] mg, one tablet orally at bedtime related to [redacted] - [redacted] tablet [redacted] mg, one tablet orally at bedtime for [redacted]. 5. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #7 with diagnoses that included [redacted];	F 580		

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F 580	Continued From page 9 [redacted] and other [redacted] Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] milligram (mg), two tablets orally two times a day for [redacted] - [redacted] tablet [redacted] mg [redacted] one tablet by mouth two times a day related to [redacted] with [redacted]. - [redacted] capsule [redacted] mg, one capsule by mouth every eight hours for [redacted]. - [redacted] mg tablet, one tablet orally three times a day for [redacted]. - [redacted] tablet [redacted] mg [redacted] tablet by mouth every eight hours for [redacted] - [redacted] tablet [redacted] mg, two tablets orally three times a day for [redacted] 6. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #8 with diagnoses that included [redacted] Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] tablet [redacted] milligram (mg), one tablet orally at bedtime for [redacted]	F 580		

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- [redacted] tablet [redacted] mg, one tablet by mouth at bedtime for [redacted].
- [redacted] tablet [redacted] mg, one tablet orally at bedtime for [redacted]
- [redacted] tablet [redacted] mg, [redacted] tablet by mouth two times a day for [redacted]
[redacted] tablet [redacted] mg, one tablet by mouth three times a day for [redacted].

7. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #9 with diagnoses that included [redacted] with [redacted].

Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM:

- [redacted] milligram (mg), one tablet by mouth at bedtime for [redacted].
- [redacted]) solution [redacted] mg/milliliter (ml), give [redacted] ml by mouth every four hours as needed for [redacted]
- [redacted] tablet [redacted] mg, one tablet by mouth at bedtime for [redacted].
[redacted] ml by mouth four times a day for [redacted].
- [redacted] tablet [redacted] mg ([redacted]), two tablet by mouth at bedtime for [redacted] management.
- [redacted] mg [redacted] ml, [redacted] ml [redacted] orally via [redacted] two times a day for

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F 580	Continued From page 11 [redacted]. - [redacted] tablet [redacted] mg, one tablet by mouth two times a day for [redacted]. [redacted] capsule [redacted] mg, one capsule by mouth three times a day for [redacted] 8. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #10 with diagnoses that included [redacted]. Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] tablet [redacted] milligram (mg) ([redacted] one tablet by mouth at bedtime for [redacted]. - [redacted] microgram (mcg)/actuation (act) ([redacted]), two [redacted] in [redacted] at bedtime for [redacted]. 9. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #11 with diagnoses that included [redacted] Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being	F 580		

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administered to the resident on [redacted] at 9:00 PM:

- [redacted] tablet [redacted] milligram (mg) [redacted] one tablet by mouth two times a day for [redacted].
- [redacted] tablet, give [redacted] mg by mouth three times a day for [redacted].
- [redacted] mg ([redacted]), one capsule by mouth three times a day for [redacted].
- [redacted] /milliliter (ml) [redacted] inject as [redacted].
- [redacted] tablet [redacted] mg ([redacted]), two tablets by mouth at bedtime for [redacted]
- [redacted] /ml, [redacted] at bedtime for [redacted].
- [redacted] tablet [redacted] mg, give [redacted] tablet by mouth at bedtime related to [redacted] with [redacted] due to known [redacted].

During an interview on 09/30/2021 at 2:57 PM, the nursing home administrator (NHA) provided copies of the facility's investigation into the failure to administer medication to the identified residents. The investigation report included a written statement by Licensed Practical Nurse (LPN) #3. The date and time of the incident/accident portion of the statement was reported as [redacted]-9PM med pass." The statement read, "I could not complete the med pass for the second cart during the 3-11 shift due to the fact I was overwhelmed dealing with severe behaviors, exit seeking and fall risk (everywhere)." The Disciplinary Action form included in the investigation indicated the facility profiled LPN #3's action as a safety violation and noted it to be unprofessional conduct. The

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LINWOOD, LLC	201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221

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Detailed Description of Offense Portion of the form read, "Group II violation - Work performance not up to professional standard. Nurse did not alert supervisor that med pass was not completed on cart one on south unit." The Action Taken portion of the form revealed LPN #3 was suspended on a start date of [redacted] and end date of [redacted]. The record did not indicate that the facility reported LPN #3's action to the board.

Although there was no reported decline in the identified residents' health related to the missed medications, the record however, did not indicate that the facility assessed the residents to ensure that they did not have any ill effects resulting from the missed medications.

LPN #3 was said to have gone on vacation and was not available for interview during the survey. Unsuccessful attempt was made to contact LPN #3 on 09/30/2021 at 4:10 PM.

During an interview on 10/01/2021 at 10:56 AM, LPN #1 stated that it was important to check for allergies before administering medication to the residents to prevent an adverse reaction. LPN #1 stated that if she encountered any challenges during med pass, she notified the unit manager or the Director of Nursing (DON). LPN #1 reviewed the [redacted] MAR and verified that the identified residents noted above were not administered their due medication on [redacted] during the 9:00 PM med pass as evidenced by lack of nurse's initial. LPN #1 stated that failure to administer medication per physician order was a medication error.

During an interview on 10/01/2021 at 11:02 AM,

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LPN #2 reviewed the [redacted] MAR of the identified residents and acknowledged the residents did not get their 9:00 PM medication as evidenced by lack of nurse's initial. Per LPN #2, failure to administer a physician ordered medication to a resident was considered a medication error.

On 10/01/2021 at 1:17 PM, the NHA and the DON were interviewed. The NHA stated she was not employed with the facility at the time of the said incident, and neither was the DON. The DON, however, clarified that she reviewed the incident report related to the event which formed the basis for why the identified residents missed their 9:00 PM medications on [redacted]. Per the DON, the synopsis of the incident report revealed LPN #3, who was the nurse assigned to the [redacted] unit, failed to complete medication (med) pass with the residents and failed to notify the shift supervisor. Per the DON, if LPN #3 had informed a supervisor of her concern, a nurse would have been sent to the unit to assist with completing the med pass. She stated that it was important to administer medications as ordered to avoid medication error. The DON stated that missed medication could affect the residents' wellbeing. The DON stated there was a safety concern for the residents on the affected unit as they were unable to verbalize their concern. The DON stated that when a medication error occurred, the facility identified the error and notified the Medical Director (MD) and the resident/resident's responsible party (RRP). The DON stated that after any medication error, the resident would have been monitored for any adverse effect from the said error. The DON stated that if an adverse effect were noted, the MD was notified, and an order was received

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F 580	Continued From page 15 which in most cases would be to send the resident to the hospital. The DON stated that the facility kept the RRP apprised on what was going on with the resident until the resident recovered. The DON acknowledged there was no documentation in the record which captured the monitoring of the identified residents or that the MD or RRP were notified. The DON acknowledged that LPN #3's action was not reported to the board. During an interview on 10/01/2021 at 1:43 PM, the MD stated that he was not made aware that a group of residents as identified above missed their medications on [redacted] at 9:00 PM. On 09/30/2021 at 2:57 PM, the NHA provided a copy of the policy titled, "Administering Medications" updated 10/2019.The policy read, " ... If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication shall contact the resident's attending physician or the facility's Medical Director to discuss the concerns." New Jersey Administrative Code § 8:39-5.1(a)	F 580		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		11/8/21

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F 760	Continued From page 16 Complaint Intake NJ148041 Based on record reviews, interviews, and facility policy review, it was determined that the facility failed to ensure residents were free from significant medications errors for eight (Residents #4, #5, #6, #7, #8, #9, #10, and #11) of 10 residents reviewed for medication errors. Specifically, the facility failed to ensure the residents received their 9:00 PM medications. This failure had the potential to affect all 20 residents who lived on the back hall of the dementia unit. Findings included: 1. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #4 with diagnoses that included [redacted] Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] milligram (mg) [redacted] mg tablet by mouth at bedtime for [redacted] - [redacted] one [redacted] in [redacted] two times a day for [redacted]	F 760	COMPLETE CARE AT LINWOOD PLAN OF CORRECTION This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that 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): 483.45(f)(2) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Disciplinary action was given to the involved LPN, regarding the identified medication errors. LPN was also counseled and re-educated regarding the facility's policy regarding Medication Errors, focusing on promptly communicating to the Unit Manager and/or Supervisor any issues that may potentially result to medication errors. ¿ The facility's Medical Director and the residents' respective attending physicians were notified of the medication errors for Residents #4, #5, #6, #7, #8, #9, #10, and #11. No actual harm was identified in any of the residents due to the missed doses. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE	

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F 760	Continued From page 17 [redacted]. - [redacted] mg [redacted], one capsule by mouth two times a day related to [redacted] - [redacted] tablet [redacted] mg [redacted] give two tablets by mouth at bedtime for [redacted]. - [redacted] tablet [redacted] mg, one tablet by mouth at bedtime for [redacted]. - [redacted] tablet [redacted] mg, four tablets by mouth at bedtime related to [redacted]. - [redacted] mg/milliliter (ml) [redacted] give [redacted] ml by mouth two times a day related to other [redacted]. - [redacted] gram (gm) [redacted] ml, give [redacted] ml by mouth two times a day for [redacted] - [redacted] one [redacted] in [redacted] at bedtime for [redacted]. - [redacted] tablet [redacted] mg, one tablet by mouth at bedtime for [redacted] - [redacted] mg [redacted], two tablets by mouth at bedtime related to [redacted] 2. Review of the [redacted] computerized physician orders indicated the facility readmitted Resident #5 with diagnoses that included [redacted]. Review of the Medication Administration Record	F 760	¿ All residents in the back hall of the dementia unit have the potential of getting affected by the same deficient practice. The MARs (Medication Administration Records) of these residents were immediately audited for medication errors and no other medication errors were found. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL 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. This is to help prevent significant medication errors from occurring. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Unit Manager or designee will review the MARs of the residents in the [redacted] of the [redacted] 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 Committee will determine the need for further audits and/or action plans on a quarterly basis.	

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F 760	Continued From page 18 (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] milligrams (mg), [redacted] one [redacted] every 24 hours as needed for [redacted]. - [redacted] tablet [redacted] mg, give one tablet by mouth three times a day related to [redacted]. - [redacted] gram (gm)/[redacted] milliliter (ml) [redacted], give [redacted] ml by mouth two times a day for [redacted]. - [redacted] microgram (mcg)/actuation (act.), one [redacted] in [redacted] at bedtime for [redacted] - [redacted] tablet [redacted] mg [redacted]), give one tablet at bedtime for [redacted]. - [redacted] tablet [redacted] mg, give one tablet by mouth every eight hours related to [redacted]. - [redacted] tablet [redacted] mg, give one tablet by mouth at bedtime for [redacted] - [redacted] tablet [redacted] mg by mouth at bedtime for [redacted] - [redacted] tablet [redacted] mg, one tablet by mouth at bedtime related to [redacted], [redacted]. [redacted] mg tablet, give two tablets orally three times a day for [redacted] management. 3. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #6 with diagnoses that included [redacted] and	F 760		

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F 760	Continued From page 19 Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] milligram (mg), one [redacted] every 48 hours as needed for [redacted]. - [redacted] tablet [redacted] mg, give one tablet orally one time a day for [redacted] - [redacted] tablet [redacted] mg, give one tablet by mouth one time a day for [redacted]. - [redacted] mg/milliliter (ml) [redacted], give [redacted] ml by mouth two times a day for [redacted]. - [redacted] tablet [redacted] mg, one tablet orally at bedtime related to [redacted]. - [redacted] tablet [redacted] mg, one tablet orally at bedtime for [redacted]. 4. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #7 with diagnoses that included [redacted] and [redacted]. Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM:	F 760		

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F 760	Continued From page 20 - [redacted] (mg), two tablets orally two times a day for [redacted] - [redacted] mg [redacted]), one tablet by mouth two times a day related to [redacted]. - [redacted] capsule [redacted] mg, one capsule by mouth every eight hours for [redacted] - [redacted] mg tablet, one tablet orally three times a day for [redacted]. - [redacted] mg [redacted] tablet by mouth every eight hours for [redacted] - [redacted] tablet [redacted] mg, two tablets orally three times a day for [redacted]. 5. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #8 with diagnoses that included [redacted]. Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: [redacted] tablet [redacted] milligram (mg), one tablet orally at bedtime for [redacted]. - [redacted] tablet [redacted] mg, one tablet by mouth at bedtime for [redacted]. - [redacted] tablet [redacted] mg, one tablet orally at bedtime for [redacted] tablet [redacted] mg, [redacted] tablet by mouth two times a day for [redacted] - [redacted] tablet [redacted] mg, one tablet by mouth three times a day for [redacted]. 6. Review of the [redacted] computerized	F 760		

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F 760	Continued From page 21 physician orders indicated the facility admitted Resident #9 with diagnoses that included [redacted]; and [redacted]. Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM: - [redacted] milligram (mg), one tablet by mouth at bedtime for [redacted]. - [redacted] ([redacted]) solution [redacted] mg/milliliter (ml), give [redacted] ml by mouth every four hours as needed for [redacted]. - [redacted] tablet [redacted] mg, one tablet by mouth at bedtime for [redacted]. - [redacted]/milliliter (ml), [redacted] ml by mouth four times a day for [redacted]. - [redacted] tablet [redacted] mg [redacted]), two tablet by mouth at bedtime for [redacted] - [redacted] mg/[redacted] ml, [redacted] mls [redacted] orally via [redacted] two times a day for [redacted] - [redacted] tablet [redacted] mg, one tablet by mouth two times a day for [redacted] - [redacted] capsule [redacted] mg, one capsule by mouth three times a day for [redacted] 7. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #10 with diagnoses that included	F 760		

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[redacted].

Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM:

- [redacted] tablet [redacted] milligram (mg) ([redacted]), one tablet by mouth at bedtime for [redacted]
- [redacted] microgram (mcg)/actuation (act) ([redacted]), two [redacted] in [redacted] at bedtime for [redacted].

8. Review of the [redacted] computerized physician orders indicated the facility admitted Resident #11 with diagnoses that included [redacted]

Review of the Medication Administration Record (MAR) for [redacted] indicated the following ordered medications were not initialed as being administered to the resident on [redacted] at 9:00 PM:

- [redacted] tablet [redacted] milligram (mg) ([redacted]), one tablet by mouth two times a day for [redacted]
- [redacted] tablet, give [redacted] mg by mouth three times a day for [redacted].
- [redacted] mg ([redacted]), one capsule by mouth three

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F 760	Continued From page 23 times a day for [redacted]. - [redacted] /milliliter (ml) [redacted]), inject as [redacted]. - [redacted] mg [redacted]), two tablets by mouth at bedtime for [redacted]. - [redacted] /ml, inject [redacted] at bedtime for [redacted] - [redacted] tablet [redacted] mg, give [redacted] tablet by mouth at bedtime related to [redacted]. During an interview on 09/30/2021 at 2:57 PM, the nursing home administrator (NHA) provided copies of the facility's investigation into the failure to administer medication to the identified residents. The investigation report included a written statement by Licensed Practical Nurse (LPN) #3. The date and time of the incident/accident portion of the statement was reported as [redacted]-9PM med pass." The statement read, "I could not complete the med pass for the second cart during the 3-11 shift due to the fact I was overwhelmed dealing with severe behaviors, exit seeking and fall risk (everywhere)." The Disciplinary Action form included in the investigation indicated the facility profiled LPN #3's action as a safety violation and noted it to be unprofessional conduct. The Detailed Description of Offense Portion of the form read, "Group II violation - Work performance not up to professional standard. Nurse did not alert supervisor that med pass was not completed on cart one on [redacted] unit." The Action Taken portion of the form revealed LPN #3 was suspended on a start date of [redacted] and end date of [redacted]. The record did not indicate that the facility reported LPN #3's action to the	F 760		

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board.

Although there was no reported decline in the identified residents' health related to the missed medications, the record however, did not indicate that the facility assessed the residents to ensure that they did not have any ill effects resulting from the missed medications.

LPN #3 was said to have gone on vacation and was not available for interview during the survey. Unsuccessful attempt was made to contact LPN #3 on 09/30/2021 at 4:10 PM.

During an interview on 10/01/2021 at 10:56 AM, LPN #1 stated that if she encountered any challenges during med pass, she notified the unit manager or the Director of Nursing (DON). LPN #1 reviewed the [redacted] MAR and verified that the identified residents noted above were not administered their due medication on [redacted] during the 9:00 PM med pass as evidenced by lack of nurse's initial. LPN #1 stated that failure to administer medication per physician order was a medication error.

During an interview on 10/01/2021 at 11:02 AM, LPN #2 reviewed the [redacted] MAR of the identified residents and acknowledged the residents did not get their 9:00 PM medication as evidenced by lack of nurse's initial. Per LPN #2, failure to administer a physician ordered medication to a resident was considered a medication error.

On 10/01/2021 at 1:17 PM, the NHA and the DON were interviewed. The NHA stated she was not employed with the facility at the time of the said incident, and neither was the DON. The

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F 760	Continued From page 25	F 760		

DON, however, clarified that she reviewed the incident report related to the event which formed the basis for why the identified residents missed their 9:00 PM medications on [redacted]. Per the DON, the synopsis of the incident report revealed LPN #3, who was the nurse assigned to the dementia unit, failed to complete medication (med) pass with the residents and failed to notify the shift supervisor. Per the DON, if LPN #3 had informed a supervisor of her concern, a nurse would have been sent to the unit to assist with completing the med pass. She stated that it was important to administer medications as ordered to avoid medication error. The DON stated that missed medication could affect the residents' wellbeing. The DON stated there was a safety concern for the residents on the affected unit as they were unable to verbalize their concern. Per the DON, the standard process would be to complete on the spot training when a medication error occurred with the nursing staff during her rounds. The DON stated the facility's process was first to prevent medication error from occurring by training nursing staff on the precautions of medication administration before they worked the floor. The DON stated that when a medication error occurred, the facility identified the error and notified the Medical Director (MD) and the resident/resident's responsible party (RRP). The DON stated the standard process was that the resident would be monitored for any adverse effect from the said error. The DON stated that if an adverse effect were noted, the MD was notified, and an order was received which in most cases would be to send the resident to the hospital. The DON stated that the facility kept the RRP apprised on what was going on with the resident until the resident recovered. The DON stated that medication error which

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 _____	C 10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT LINWOOD, LLC	201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221

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F 760	Continued From page 26 caused harm to a resident was reported to the State Health Department. The DON acknowledged there was no documentation in the record which captured the monitoring of the identified residents or that the MD or RRP were notified. The DON acknowledged that LPN #3's action was not reported to the board. During an interview on 10/01/2021 at 1:43 PM, the MD stated that he was not made aware that a group of residents as identified above missed their medications on [redacted] at 9:00 PM. On 09/30/2021 at 2:57 PM the NHA provided a copy of the policy titled, "Administering Medications" updated 10/2019. The policy reads in part, "Medications shall be administered in a safe and timely manner and as prescribed. ...Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified ..." New Jersey Administrative Code § 8:39-29.2(d)	F 760		