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 _____	03/30/2021

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 STANDARD SURVEY CENSUS: 104 SAMPLE SIZE: 21+1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19	F 000		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		5/14/21

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

Electronically Signed | 04/07/2021

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F 695	Continued From page 1 Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to obtain a physician order for the use of [redacted] for [redacted] residents reviewed for [redacted] (Resident [redacted] and Resident [redacted]). This deficient practice was evidenced by the following: 1. During the initial tour of the [redacted] on 03/19/21 at 11:29 AM the surveyor observed Resident [redacted] room which had an [redacted] in the room turned on to [redacted] Resident [redacted] was observed [redacted] The surveyor interviewed the resident who said that they [redacted] On 03/22/21 at 10:05 AM Resident [redacted] was observed lying in bed asleep with the [redacted] According to the Admission Record, Resident [redacted] was [redacted] The surveyor reviewed the Minimum Data Set (MDS) assessment tool, dated 11/10/2020 and 2/5/2021. Resident [redacted] was noted to have a Brief Interview for [redacted]. Both MDS's also revealed that Resident [redacted] The surveyor reviewed the Order Summary Reports dated 05/01/2020-06/30/2020 and	F 695	1. A physicians order to place [redacted] was received for resident [redacted] on [redacted] and entered in the residents medical Record. Residents Care Plan was updated to include [redacted]. A physicians order to place [redacted] was received for resident [redacted] on [redacted] and entered into the residents Medical Record. Residents MDS was updated to include [redacted]. 2. All residents have the potential to be affected by this deficient practice. 3. An audit was done for all residents on [redacted] to ensure physicians order and care plans were present and no other orders were found missing. 4. Nursing Supervisor will conduct an audit twice a month on all residents on [redacted] to ensure that physician orders and care plans are present and current. Any concerns will be addressed immediately and reported to the Director of Nursing. Director of Nursing will report any significant findings at the quarterly QA Meeting x3 quarters.	

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F 695		F 695		

Continued From page 2

01/01/2021-03/26/2021 and noted there was no physician order [redacted].

A review of the Weights and Vitals summary with Vital of O2 Sats (saturation) indicated that on 12/12/20, 2/10/21 and 3/9/21 the resident had [redacted].

A review of the Progress notes dated 10/19/20, 1/21/21 and 3/13/21 indicated the Resident [redacted]

A review of the June 2020 Medication Administration Record (MAR) indicated a physician order fo [redacted] with an order date of 07/16/2018 and a discontinue date of 6/2/2020.

A review of Resident [redacted] care plan did not include the resident's [redacted]

The surveyor interviewed the resident's assigned Licensed Practical Nurse (LPN#1)on 03/25/21 at 01:12 PM. She stated Resident [redacted] has [redacted] and uses [redacted] as needed. LPN #1 did also state that a physician's order is [redacted] LPN #1 and the surveyor reviewed the physician orders for Resident [redacted] LPN #1 agreed there was no order [redacted] and that there should be.

The surveyor interviewed the LPNUM on 03/25/21 at 01:56 PM who told the surveyor the LPNUM said she did not know why the [redacted] was discontinued in June (2020). She went on to say Resident [redacted] and had no physician order [redacted]. She also said the policy is a physician order for [redacted] is required.

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F 695	Continued From page 3	F 695		

2. During the initial tour of the [redacted] on 3/19/2021 at 12:22 PM the surveyor observed Resident [redacted] lying on their bed with their head at the foot of the bed and receiving [redacted] The surveyor also observed a red magnetic sign on the door frame that read [redacted]."

On 3/24/2021 at 9:37 AM Resident [redacted] was observed in their room [redacted] via a [redacted]

According to the Admission Record, Resident [redacted]

According to the MDS dated 2/12/2021, Resident [redacted] had a [redacted], [redacted] The MDS also noted that the resident did not [redacted]

A review of the Medication Review Report dated 2/1/2021 -3/31/2021 included the following physician order dated 3/23/2021: [redacted]

A review of the Weights and Vitals summary with [redacted] 3/16/2021, 3/17/2021, 3/18/2021, 3/19/2021, 3/20/2021, and 3/22/2021 the resident received [redacted]

A review of the Progress Notes dated 3/17/2021 indicated the resident had received [redacted] via

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F 695		F 695		

Continued From page 4

Executive Order 26, 4.b.

A review of the March 2021 Treatment Administration Record (TAR) revealed that on 3/23//2021 Resident [redacted] had an order to "[redacted] There was Executive Order 26, 4.b. [redacted]

A review of Resident [redacted] care plan revealed that a care plan intervention for [resident name] has" Executive Order 26, 4.b. [redacted] dated 3/23/2021.

On 3/25/2021 at 11:36 AM the surveyor interviewed Resident [redacted] who stated, "I have been using Executive Order 26, 4.b. [redacted]

During an interview on 3/25/2021 LPN #2, who was responsible for Resident [redacted] care, stated, "He/she Executive Order 26, 4.b. [redacted] He/she was Executive Order 26, 4.b. [redacted] I thought there was an ancillary order for the [redacted]

During an interview on 3/25/2021 at 1:57 PM the LPNUM stated, "He/she did not have an order for Executive Order 26, 4.b. [redacted] He/she should have had an order to Executive Order 26, 4.b.

A review of a facility policy titled Oxygen Administration with an updated date of 10/2019, revealed under the Preparation section, 1. Verify that there is a physician's order for this procedure.

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F 695	Continued From page 5 NJAC 8:39-27.1(a)	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation in a safe and consistent manner designed to prevent food borne illness. This deficient practice was evidenced by the following: On 3/19/2021 from 10:04 AM to 10:29 AM the surveyor, accompanied by the Director of Dining Services (DDS), observed the following in the kitchen:	F 812	1. The metal bowls and desert dishes were rewashed and sanitized. The plastic forks and sliced deli were immediately discarded. Thermometers were placed in freezers. High temp. dish machine was cleaned of all debris. 2. All residents have the potential to be affected by this deficient practice. 3. All refrigerator and freezers were	5/14/21

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F 812	Continued From page 6 1. On an upper shelf of the pot/pan dry storage rack, a stack of 6 metal bowls were not stored in the inverted position and leaving the working surface exposed. On interview the DDS stated, "They should be stored inverted. They are not wet though." The DDS removed the bowls to be rewashed and sanitized. 2. In the dry storage room on an upper shelf an opened cardboard box contained plastic forks. The forks were removed from the plastic bag and were exposed. On interview the DDS stated, "They (the forks) should be in a plastic bag that is closed. I'm going to throw them in the trash." The DDS threw the box of plastic forks in the trash." 3. The surveyor reviewed the Complete Care at Linwood Area Refrigerator/Freezer Temperatures for Ice Cream 1 and Ice Cream 2 freezers. The logs were both completed for the dates 3/1/2021 to 3/18/2021. The logs had no temperatures recorded for the AM or PM for the date 3/19/2021. The surveyor and the DDS were unable to find an internal thermometer in Freezer 1 and Freezer 2. On interview the DDS stated, "Neither freezer has a functioning internal thermometer, I think my staff is just writing them in (temperatures)." 4. On the top shelf inside the Cook's box the surveyor noted a clear, hard plastic container holding sliced deli cheese. The container had no open or use by dates. On interview the DDS stated, "I'm throwing it out, it's not labeled." On 3/29/21 from 9:49 AM to 10:29 AM the surveyor, accompanied by the DDS observed the following in the kitchen:	F 812	checked to ensure they have working thermometers present and no others were found missing or broken. All dietary staff were inserviced on facility policy regarding proper food storage, ware washing and dishroom and sanitizing procedures. 4. Dietary Director has created an audit form to be completed daily ensuring working thermometers are present, temps have been taken and all locations have been checked for uncovered or unlabeled food. All concerns will be addressed immediately and brought to the attention of the director. Dietary Director will report any significant findings at the quarterly QA Meeting x 4 quarters.	

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F 812	Continued From page 7	F 812		

1. Observation of the top of the high temperature dish machine revealed unidentified brown debris, a kitchen knife, a pen, and a garden type hose sprayer/nozzle. On interview the DSD stated, "The machine should be cleaned after each service or use. We are coming off the weekend. I guess it didn't get cleaned. The dietary aides are responsible for the cleaning of the dish machine. I do daily walk throughs. It's Monday that may have been from the weekend."

2. In the microwave/prep area 4 stacks of bread and butter and dessert dishes were stacked on a counter and not inverted or covered, exposing the eating surface. On interview the DDS stated, they should be covered when not in use. Were going to run them through the machine and reclean them."

The surveyor reviewed an undated facility policy titled "Food Storage". The policy revealed the following under the heading Cold Storage:

4. "All foods will be stored either wrapped or in closed storage containers and be clearly dated and labeled."

The surveyor reviewed an undated facility policy titled "Complete Care Management Warewashing". Under the Procedures section the policy revealed the following:

4. "All dishware will be air dried and properly stored."

The surveyor reviewed an undated facility policy titled "Completecare Management Proper Dishroom and Sanitizing Procedures". The policy revealed the following under the Procedures

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F 812	Continued From page 8 section: 2. "Always start with clean dishwasher and area. Make sure heating element is on and tanks of dishwasher are full. Always check detergent and rinse additive for product. Product is automatically dispensed." 6. "When finished clean dishwasher screens, wash arms and nozzles. Scrub all surfaces with detergent. Weekly descale machine with descaler." NJAC 8:39-17.2 (g)	F 812		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315185		11/8/2021

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 05/14/2021	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 05/14/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/30/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO