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 05/19/2023

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 Survey Dates: 05/16/23 through 05/19/23 Survey Census: 134 Sample Size: 45 Supplemental Sample Size: 5 Complaints: #NJ156251, NJ150930, NJ151188, NJ152747, NJ157731 A Recertification Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health from 05/16/23 through 05/19/23. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the	F 550		6/30/23

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

Electronically Signed | 06/15/2023

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F 550	Continued From page 1 provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide privacy to one of 43 residents (Resident (R)101) on the South unit during care. The failure created the potential for R101 to be exposed to other residents, staff, and visitors. Findings include: Record review of the "Medical Diagnoses," located in the electronic medical record (EMR), revealed R101 was admitted to the facility on Ex Order 26. 4B1 with diagnoses including Ex Order 26. 4B1 [redacted]. The Quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of Ex Order 26. 4B1 [redacted], located in the "MDS" tab of the EMR, revealed a	F 550	1. All Residents have the potential to be affected. 2. LPN 1 declined reeducation on privacy and resigned her position. All other nursing staff on the Unit where Resident 1 resides were immediately educated on the importance of Dignity and Privacy while caring for Resident 1. All nursing staff including Certified Nursing Assistants will be in-serviced on maintaining all Resident's Rights to Dignity/Privacy while care and treatment is being delivered. 3. Audits for monitoring the Resident's Right to Dignity and Privacy while nursing staff provides care and/or treatments will be completed by DON and/or their designee 4x per week for 4 weeks and	

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F 550	Continued From page 2 Ex Order 26. 4B1 score of Ex Order 26. 4B1 out of 15, indicating Ex Order 26. 4B1 . R101 was assessed to require extensive assistance of two persons for Ex Order 26. 4B1 . R101 was observed on 05/16/23 at 3:47 PM lying in bed in his room. The door to the room was open as well as the privacy curtain which permitted the resident to be seen, without obstruction, from the doorway and hall. R101 was observed with his gown up, exposing his Ex Order 26. 4B1 and Ex Order 26. 4B1 brief. A Licensed Practical Nurse (LPN1) was providing care for R101's Ex Order 26. 4B1 . In the hall at the time of the observation were two surveyors, the Maintenance Director (MD), Administrator (ADM), Corporate Maintenance Director, a housekeeper, and other residents. LPN1 was interviewed at 03:50 PM and asked how the resident's privacy is maintained during care? LPN1 said "I usually pull the curtain but didn't because (state) was in the hall" and she "thought we wanted to watch." Observation of the care of R101's Ex Order 26. 4B1 was not requested by the surveyors. Review of the facility's policy and procedure titled "Quality of Life - Dignity," dated 01/20/23, revealed "Staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures." During an interview on 05/19/23 at 10:00 AM, the Director of Nursing (DON) stated she would add	F 550	then 2x per week for 2 months. 4. The DON and/or their designee will provide all weekly and monthly audits to the QAPI committee monthly, x3 months, to ensure compliance.	

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F 550	Continued From page 3 the exposure to LPN1's disciplinary action, "she should not have done that."	F 550		
F 576 SS=E	NJAC 8:39-4.1(a)16 Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of	F 576		6/30/23

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F 576	Continued From page 4 electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff, and Ombudsman interviews, the facility failed to provide access to the resident identified telephone, for three of four units (West, East, and North), where calls can be made without being overheard. This failure created the potential for residents to be without private telephone communication. Findings include: On 05/17/23 at 1:00 PM, a Resident Council Meeting was conducted with seven residents (R31, R36, R39, R72, R84, R89, and R91) including the Resident Council President and the Resident Council Vice President. The residents present regularly attend the facility's monthly Resident Council meetings. R91 said the "Resident Telephone," located at the end of the West Wing just before entering the secured South wing, is always blocked by wheelchairs and the lift." R91 further stated "*Ex Order 26. 4B1* [redacted]" The other six residents, in attendance, confirmed R91's statement. R91 stated the concern had been raised numerous times with the Ombudsman (resident advocate) without any changes being	F 576	1. All residents on West, East and North Units have the potential to be affected. 2. For the Residents who were identified, R31 has his own cell phone, R36 was provided a cell phone, R39 declined a cell phone, R72 was just ordered a new cell phone (because lost one), R84 has a cell phone, R89 is unable to dial phone without assistance and will be aided by Social Service, R91 has own cell phone. Resident Telephone has been moved to the Front Conference Room which allows all wheelchair sizes and has a door for privacy. This information was delivered via a letter from Social Services to all residents in the facility and will be discussed during Resident Council meetings. Assistance will be provided by the Receptionist during normal business hours and the Nurse Supervisor or Charge Nurse on the off hours. Cell phones will be provided for any long-term residents unable to bring in their own phone, or unable to access the phone in the Front Conference Room. All staff will be in-serviced to assist residents, as needed, in the Front Conference Room to make and/or receive private phone calls on the Resident Telephone.	

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F 576	Continued From page 5 made. The specified "Resident Telephone" was located at the end of the West wing, in an area off the hallway. A sign was posted next to the telephone identifying it as the "Resident's Telephone." Three stationary chairs were placed along the wall, under the windows, next to the telephone which was mounted on the wall. A privacy curtain was hung along the outside of the area to be able to pull around the telephone which gave visual privacy, but no privacy from being overheard during a telephone call. The following observations were made of the identified Resident Telephone: On 05/16/23 at 5:00 PM, the resident telephone, a black phone on the wall, was blocked by multiple wheelchairs. The telephone was not accessible for use. On 05/17/23 at 9:40 AM, the resident telephone was blocked by a wheelchair and a Ex Order 26. 4B1 [redacted]. The telephone was not accessible for use. On 05/17/23 at 4:41 PM, the resident telephone was blocked by two wheelchairs, a reclining [redacted], and a Ex Order 26. 4B1. The telephone was not accessible for use. On 05/17/23 at 9:45 PM, the resident telephone was observed to have three wheelchairs blocking the telephone. The telephone was not accessible for use. On 05/18/23 at 9:44 AM, the resident telephone was observed to be blocked by a wheelchair, a Ex Order 26. 4B1 behind the wheelchair, and	F 576	3. The Social Services Director and/or their designee will complete audits 3x per week, x4 weeks, then monthly x2 months regarding informing all new admissions to Long Term Care and presenting to Resident Council where the Resident Telephone is located and how to access. 4. The Social Services Director and/or their designee will provide all weekly and monthly audits to the QAPI committee monthly, x3 months, to ensure compliance.	

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F 576	Continued From page 6 another wheelchair on the side of the Ex Order 26. 4B1 . The telephone was not accessible for use. The same observation was made at 10:10 AM. The telephone was not accessible for use. On 05/18/23 at 11:50 AM, the resident telephone was blocked by a wheelchair. The telephone was not accessible for use. On 05/18/23 at 12:29 PM, the resident telephone was blocked by a wheelchair. The telephone was not accessible for use. On 05/18/23 at 5:37 PM, the resident telephone was blocked by two wheelchairs and a Ex Order 26. 4B1. The telephone was not accessible for use. In an interview on 05/19/23 at 10:05 AM, the Maintenance Director stated the resident phone was not his department. In an interview on 05/19/23 at 1:05 PM, the Ombudsman stated the resident telephone has been "blocked for years." The Ombudsman said "the resident telephone used to be in the front of the building and was private, but some wheelchairs couldn't fit so it was moved to the West wing." In an interview on 05/19/23 at 5:30 PM, the Director of Nursing (DON) stated she was made aware of the resident telephone being blocked. The DON confirmed that the wheelchairs and Ex Order 26. 4B1 were placed in front of the telephone blocking access. The DON stated "It's a struggle with the age and size of the building to make sure there is enough space especially for the large wheelchairs. The telephone used to be	F 576		

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F 576	Continued From page 7 in the front, but the wheelchairs could not fit and the residents wanted the phone closer to their unit so it was moved to the West wing."	F 576		
F 584 SS=D	NJAC 8:39-4.1(a)20 Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting	F 584		6/30/23

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F 584	Continued From page 8 levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for 43 facility residents on one of four wings (South). For seven of 43 residents (Resident (R) 76, R17, R60, R122, R35, R30, R82) the environment was not maintained. Throughout the South unit the temperature was not controlled in a comfortable range creating a warm environment for residents, staff, and visitors. Findings include: ENVIRONMENT Observations of the South wing, a secured unit with 43 residents, on 05/16/23 10:44 AM, revealed the following: Resident (R)76's room: Part of a floor tile, approximately five by eight inches, near the head of bed B was heavily damaged with tile missing. There was an unsightly glue-like substance underneath the length of the windowsill that appeared to have run down and dried on the wall. The paint on the bathroom door was heavily marred and scarred. R17's room: There was a broken stationary chair,	F 584	1. All Residents on the South Unit have the potential to be affected. 2. 5.17.23 - Rm 34 (R76) Loose tile was removed and replaced, the glue-like substance under windowsill was removed, and the bathroom door was repaired and painted. 5.17.23 – Rm 37 (R17) Personally owned broken chair armrest was fixed and replaced. 5.17.23 - Rm 39 (R60) Chair rail removed and replaced. The broken headboard and footboard were removed and replaced. 5.17.23 – Rm 23 (R122) Broken chair rail at head of Bed A removed and replaced. The wooden bedframe was replaced. The chair rail at the head of Bed B was removed and replaced. The headboard and footboard were removed and replaced. 5.17.23 - Rm 23 (R35) Bubbled paint above the head of bed B, was scrapped, patched, and painted. The bathroom door and door frame are scheduled to be cleaned and painted. 5.17.23 – Rm 24 (R30) Chair rail separated from the wall, at head of Bed A, leaving a ½ inch gap re-secured, caulked,	

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F 584	Continued From page 9 missing the right arm which exposed an approximate seven-inch spindle where the armrest should have been. The armrest was on top of the dresser. R60's room: There was a missing chair rail at the head of bed A exposing unpatched and unpainted wall. There was a screw, approximately 1/2 inch out from the wall where the chair rail should have been. R122's room: There was a broken chair rail at the head of bed A. The wooden bedframe was heavily marred and scarred. The chair rail at the head of bed B was heavily marred and scarred. The wooden headboard and footboard were heavily marred and scarred. R35's room: There was an approximate three by three-inch area of bubbled paint above the head of the B bed. The bathroom door and door frame were heavily marred and scarred. R30's room: There was a broken chair rail, separated from the wall, at the head of bed A. The separation, greater than 1/2 inch, could fit a person's fingers underneath where nails were exposed. There was an approximate two by four inch corner of the headboard missing, which revealed a hole through the missing particle board. The footboard had a large chunk of particle board missing, approximately seven by nine inches, exposing the metal bedframe underneath the bed. The wall by the window was patched but not painted. R82's room: The chair rail, at the head of bed A was heavily marred and missing pieces.	F 584	and nails no longer exposed. Headboard and Footboard on Bed A replaced. Wall by the window painted. 5.17.23 – Rm 25 (R82) Chair rail removed and replaced. 5.17.23 - The cracked and marred overbed table in assisted dining room was thrown away. 5.17.23 - The five feet of baseboard missing from half wall and 3 inches of baseboard at the end of the half wall in the assisted dining room were replaced. 5.19.23 - The carpets in all hallways and assisted dining room were safely cleaned via hot water extraction. All South Unit carpets are scheduled to be safely cleaned and stains removed, via hot-water extraction, by an outside vendor and will be cleaned ongoing every 3 months and more often as needed. 5.17.23 - The Solarium kitchenette cabinet doors were redrilled and screwed in. The locks on the half doors leading into the kitchenette will have self-closures that connect to a self-securing system. Temperature Levels 5.16.23 – Temperature taken using the proper air temperature thermometer, immediately after using Electronic Surface Temperature Gun, revealed hallway temperature of 76 degrees and 78 degrees in the assisted dining room nearest the split air conditioning unit in the presence of surveyor, MD, Regional MD and “Corp Admin”. Windows were closed in Residents rooms due to individual air conditioning unit on in those rooms. 5.16.23 – Split Air Conditioner Units in the	

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F 584	Continued From page 10 An over the bed table, used in the assisted dining room, was heavily marred, had missing and cracked edges and peeling veneer. Approximately five feet of baseboard was missing from a half wall in the assisted dining room. The wall was heavily marred with holes in the drywall where the baseboard should have been. One end of the half wall was missing approximately three inches of baseboard which exposed damaged drywall. This was located directly under a resident dining table. The carpet in the two hallways was dingy and stained. On 05/16/23 at 1:17 PM, the kitchenette, located in the solarium, was observed. Underneath the sink were two cabinet doors with handles. A hole had been drilled above each handle in the corner of each cabinet door. In each hole was a screw, approximately two inches in length, that was not screwed in and could be easily removed from the hole. The kitchenette had a half door on each end of the area with locks, however the locks were not engaged allowing access to residents. The Maintenance Director (MD), Corporate Maintenance (CM) person, Corporate Administrator (Corp Admin), and the Administrator in Training (AIT) were shown the conditions on 05/16/23 at 2:24 PM and on 05/19/23 at 10:05 AM. The MD confirmed all areas pointed out during the two environmental tours. The MD stated rounds of the South wing were conducted monthly. The MD was asked to provide documentation of the monthly rounds or a plan to fix the identified areas. No additional documentation was provided.	F 584	assisted dining room turned on for the first time of the Spring season due to prior unseasonably cooler weather. 5.17.23 – HVAC vendor dispatched to recharge split system servicing assisted dining room on South Unit and split system servicing front of the building dining room as per normal annual opening of the AC system. HVAC vendor found and replaced leaking valve on South Unit split AC system. 5.16.23 – MD removed both Split Unit's air filters, found minimal dust build-up, cleaned filters immediately and replaced them back into both Split Units. 3. Education provided to Maintenance Director from Corporate Maintenance Director regarding environmental rounds in Resident Rooms, Resident Dining and Resident Common Spaces that included how to address all environmental issues found during rounds. The Maintenance Director and/or their designee will conduct Environmental Rounds Audits 1x week for 4 weeks and then 1x per month ongoing on all Units. The Maintenance Director provided education to all staff to ensure resident room windows are closed during warmer weather days and to ensure room air conditioning units are set to a comfortable temperature, per resident choice. Maintenance Director and/or their designee will monitor air temperatures 1x daily (and as needed) on all units ongoing to maintain a comfortable temperature throughout the facility not to exceed 81 degrees. 4. The Maintenance Director and/or their designee will provide all weekly and	

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(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 584	Continued From page 11 TEMPERATURE LEVELS On 05/16/23 at 10:44 AM, the South wing, a secured unit, was observed to be stuffy and hot. At 2:38 PM on 5/16/23, the MD was asked to take air temperatures of the South wing. Using an electronic temperature gun, the MD registered a hallway temperature of 83.5 degrees, an assisted dining room temperature of 85.5 degrees, and a temperature of 84.0 degrees across the assisted dining room nearest the split air conditioning unit. The MD pointed the temperature gun at the right side of the split air conditioning unit which read 84.0 degrees. When asked how the temperature felt to the MD, he stated "this is what it's reading" the temperatures noted on the "gun." The Corp Admin stated, on 05/16/23 at 3:03 PM, that "the air conditioning units were just turned back on earlier today." The Corp Admin said "I had to shut all the windows, it's a warm day today." In an interview on 05/16/23 at 12:07 PM, Certified Nursing Assistant (CNA) 3 said "it's hot in here." In an interview on 05/16/23 at 3:43 PM, CNA2 said "it gets a little warm, more people out, it was very warm today, I'm sweating." In an interview on 05/16/23 at 4:42 PM, CNA4 said "it's hot, it's hot, that's why we have a fan in nurses' station." The CADM, stated on 05/16/23 at 4:35 PM, "it's the warmest day for past two weeks."	F 584	monthly audits to the QAPI committee monthly, x3 months, to ensure compliance.	

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Review of the weather report showed outside high temperatures as: 05/14/23 79.0 degrees, 05/15/23 80.0 degrees; and 05/16/23 79.0 degrees.

When asked how long the air conditioning had been off, the Adminsitrator said, on 05/16/23 at 04:03 PM, that he did not know. On 05/16/23 at 04:15 PM, the MD said "today was the first day [this year] it was turned on." The CM said they "need to keep it comfortable 75-80, no more than 81 or less than 71."

In an interview on 05/16/23 at 4:20 PM, the CM said he "expects daily rounds to check temps but doesn't expect them to write it down, just to keep an eye." On 05/16/23 at 4:35 PM, the Corp Admin said "all other units were turned on today, but not the secured unit." The Corp Admin did not state why the secured unit air conditioners were not turned on.

In an interview on 05/16/23 at 6:34 PM, a family member (F)1 said the staff kept the windows open for air circulation, "that's what I'm told."

On 05/16/23 at 4:35 PM, the split air conditioning unit was observed. The left side of the unit was blowing warm air while the right side was not blowing cool or warm air.

At 4:45 PM on 05/16/23, the MD was observed to remove an air filter from the split air conditioners on the South wing. The filter was noted to be very dirty with a heavy build- up of dirt and dust. On 05/17/23 at 8:45 AM, the MD said he had not changed the filter since last year.

Two maintenance manuals were reviewed, on

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F 584	Continued From page 13 05/18/23 at 4:55 PM. 1."Mitsubishi Electric split type air conditioners indoor unit MSZ=GL18NA "Cleaning" Air filter (nano platinum filter) clean every two weeks. Air cleaning filter (anti-allergy enzyme filter) back side of air filter every 3 mon. [months] Important, Clean the filters regularly for best performance and to reduce power consumptions. Dirty filters cause condensation in the air conditioner which will contribute to the growth of fungi such as mold. Is therefore recommended to clean air filters every 2 weeks." 2."Bryant Single Package Rooftop Cooling only, nominal 3-10 tons with Puron (R-410A) refrigerant. This unit is designed for use with Puron refrigerant. Do not use any other refrigerant in this system." On 05/17/23 at 12:15 PM, the MD was asked for documentation to show that the air conditioning units were checked and serviced on a routine basis including filter changes. No documentation was provided prior to exit from the facility. NJAC 8:39-4.1(a)11 NJAC 8:39-31.4(a) NJAC 8:39-31.8(e)	F 584		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 692		6/30/23

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F 692	Continued From page 14 comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, resident, staff, and Ombudsman interviews, the facility failed to provide a functioning ice/water machine on one (West) of four wings. This deficient practice had the potential to affect the proper hydration status of 38 residents who resided on the West unit. Findings include: 1. Review of R96's electronic face sheet, located on the "Profile" tab of the electronic medical record (EMR) revealed R96 was admitted to the facility on Ex Order 26. 4B1 with diagnoses that included Ex Order 26. 4B1 . Review of R96's "Physician Orders," located under the "Orders" tab of the EMR, revealed no orders for a Ex Order 26. 4B1 for R96. Review of R96's quarterly "Minimum Data Set	F 692	1. All Residents on West Unit have the potential to be affected. 2. 6.8.23 - Facility purchased and installed a new ice/water machine on the West Unit. Education for all Nursing and Activity staff members will be conducted by the DON and/or their designee on the following policy and procedures: Ice Water Pass to Residents. Education conducted by the Regional Maintenance Director with all Maintenance department employees regarding checking Ice/Water Machine for proper function and cleaning. 3. Ice Water Pass Audits will be completed by the DON and/or their designee 3x a week x4 weeks, then 1 time a week x2 months. Ice/Water Machine will be checked/audited for proper function by the Maintenance Director and/or their designee 1x week ongoing per the Preventative Maintenance	

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F 692	Continued From page 15 (MDS)," with an Assessment Reference Date (ARD) of Ex Order 26. 4B1 and located under the "MDS" tab of the EMR, revealed R96 had a "Ex Order 26 [redacted]" score of Ex Ord out of 15, which indicated R96 was Ex Order 26. 4B1 [redacted]. The assessment recorded R96 was Ex Order 26. 4B1 [redacted], both on and off the unit, and did not require set-up help from staff. During an interview on 05/16/23 at 12:42 PM, R96 stated the ice machine on the west unit had been out of order and he had been told that he could not go and get his own water and ice. R96 stated he did not receive any ice or water from staff during the previous night or on this day. R96 stated the ice machine had been out for months. 2. Review of the monthly Resident Council Meeting minutes, dated 04/25/23, revealed "water/ice machine on West unit broken." The staff response was noted "still working on a part for the ice machine. Residents are allowed to use the ice/water machine in North wing." 3. On 05/17/23 at 1:00 PM, a Resident Council Meeting was conducted with seven residents (Resident (R) 31, R36, R39, R72, R84, R89, and R91) including the Resident Council President and the Resident Council Vice President. The residents present regularly attended the facility's monthly Resident Council meetings. R31 stated the ice/water machine on the West wing had been broken for six months. The residents in attendance confirmed R31's statement. R91 stated, 'Ex Order 26. 4B1 [redacted]" R31 stated the staff told the West wing residents they could go get ice on the North	F 692	Program. Ice/Water Machine will be cleaned 1x quarterly per manufactures recommendation, or more as needed, by Maintenance Director and/or their designee per the Preventative Maintenance Program and documented in electronic Preventative Maintenance software program. 4. The Maintenance Director and/or their designee will provide all weekly and monthly audits to the QAPI committee monthly, x3 months, to ensure compliance.	

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F 692	Continued From page 16	F 692		

wing, however not all in attendance wanted to go off the West wing for ice/water. R91 stated not all the residents could get themselves up the ramp to get into the North wing to get ice/water by themselves. R91 stated, "*Ex Order 26. 4B1* [redacted]." The residents in the meeting stated they wanted to be able to access ice/water on their own and when they desired. The statement was confirmed by the seven residents.

Observations were made of the West wing ice/water machine throughout the survey, from 05/16/23 through 05/19/23, by four surveyors. The ice/water machine was located at the end of the West wing, across from the Nurses Station, with easy access for residents and staff. A sign posted on the ice/water machine read, "Out of Service."

In an interview on 05/19/23 at 10:05 AM, the Maintenance Director (MD) stated, "It's been broken for a while, probably more than two months." The Corporate Maintenance (CM) person stated he did not know how long it had been broken, however he knew they were waiting for a part. No documentation or dates were provided, when requested on 05/19/23, to show when the part was ordered.

The entrance to the North unit, from the West unit, was observed on 05/19/23 at 10:15 AM and revealed an incline in the hall just after the Activity room door leading up to the closed North unit entrance.

During an interview on 05/19/23 at 1:32 PM, the Ombudsman confirmed the ice machine on the west unit had been out for months. She stated

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F 692	Continued From page 17 there was an ice machine on the rehabilitation hall, but the residents would have to go up a ramp. The Ombudsman stated if a resident was in a wheelchair, it would be hard for the resident to move up or down the ramp. She stated the facility had reported the part was on order, but the ice machine still was not fixed. During an interview on 05/19/23 at 2:13 PM, the Administrator, Corporate Maintenance and Maintenance Director confirmed the ice machine on the west unit had been out of order for a few months. The Maintenance Director stated there was another ice/water machine ordered and a contractor was coming to fix the current machine. On 05/19/23 at 2:28 PM, the MD was asked to provide documentation of when the ice/water machine part was ordered. The MD stated, "The Administrator had the paperwork and was fiddling with it." On 05/19/23 at 4:40 PM, the Administrator and MD provided a purchase order, dated 05/19/23, which revealed a new ice machine was ordered on 05/19/23. No other documentation was provided to show when the ice/water machine part was ordered.	F 692		
F 761 SS=D	NJAC 8:39-27.2(k) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		6/30/23

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F 761	Continued From page 18 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to ensure one of two medication carts on the secured unit was locked while unattended. This had the potential to affect 10 (Resident (R) 80, R93, R30, R57, R240, R115, R13, R95, R17 and R10) of 43 residents who were at risk for wandering on the secured unit. Findings Include: Review of R80's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab of the electronic medical record (EMR) and with an Assessment Reference Date (ARD) of [redacted],	F 761	1. No residents were directly affected. All residents on the South Unit have the potential to be affected. 2. All facility Nurses re-educated by the DON and/or their designee on the facility's Storage of Medications specifically highlighting the importance of keeping the medication carts and storage of medications locked and always secured when a nurse is not directly present. The education of all existing nurse staff was immediate and will be conducted for all new hires ongoing. 3. DON and/or their designee will conduct compliance audits of proper	

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F 761	Continued From page 19 revealed R80 had a "Ex Order 26. 4B1 " score of Ex Order 26. out of 15, which indicated R80 was Ex Order 26. 4B1 . The MDS recorded R80 had diagnoses which included Ex Order 26. 4B1 . Review of R93's significant change "MDS," located under the "MDS" tab of the EMR and with an ARD of Ex Order 26. 4B1, revealed R93 had a " " score of out of 15, which indicated R93 was Ex Order 26. 4B1 and had diagnoses including Ex Order 26. 4B1 . During the days of the survey, R93 was observed ambulating throughout the secured unit. Review of R30's annual "MDS," located under the "MDS" tab of the EMR and with an ARD of Ex Order 26. 4B1, revealed R30 had a " " score of Ex Order 26. out of 10, which indicated R30 was Ex Order 26. 4B1 . Review of R57's quarterly "MDS," located under the "MDS" tab of the EMR and with an ARD of Ex Order 26. 4B1, revealed R57 had a " " score of out of 15, which indicated R57 was Ex Order 26. 4B1 ; had diagnoses which included Ex Order 26. 4B1 . Review of R240's quarterly "MDS," located under the "MDS" tab of the EMR and with an ARD of Ex Order 26. 4B1, revealed R240 had a " " score of Ex Order out of 15, which indicated R240 was Ex Order 26. 4B1	F 761	storage of medications 3x week x4 weeks, then 1x per week monthly x2 months 4. The DON and/or their designee will provide all weekly and monthly audits to the QAPI committee monthly, x3 months, to ensure compliance.	

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F 761	Continued From page 20 Ex Order 26. 4B1 ; had diagnoses which included Ex Order 26. 4B1 . Review of R115's significant change "MDS," with an ARD of Ex Order 26. 4B1 and located under the "MDS" tab of the EMR, revealed R115 had a "Ex Order 26. 4" score of Ex Order 26. out of 15, which indicated R115 was Ex Order 26. 4B1 ; had diagnoses which included Ex Order 26. 4B1 . Review of R13's quarterly "MDS," with an ARD of Ex Order 26. 4B1 and located under the "MDS" tab of the EMR, revealed R13 had a "Ex Order 26. 4" score of Ex Ord out of 15, which indicated R13 was Ex Order 26. 4B1 ; had diagnoses which included Ex Order 26. 4B1 . Review of R95's significant change "MDS," with an ARD of Ex Order 26. 4B1 and located under the "MDS" tab of the EMR, revealed R95 had a "Ex Order 26. 4" score of Ex Order 26 out of 15, which indicated R95 was Ex Order 26. 4B1 ; had diagnoses which included Ex Order 26. 4B1 . Review of R17's significant change "MDS," with an ARD of Ex Order 26. 4B1 and located under the "MDS" tab of the EMR, revealed R17 had a "Ex Order 26. 4" score of Ex Order 26 out of 15, which indicated R17 was Ex Order 26. 4B1 ; had diagnoses which included Ex Order 26. 4B1	F 761		

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F 761	Continued From page 21 Ex Order 26. 4B1 [redacted].	F 761		

Review of R10's significant change "MDS," with an ARD of Ex Order 26. 4B1 and located under the "MDS" tab of the EMR, revealed R10 had a "Ex Order 26. 4" score of Ex Order 26 out of 15, which indicated R10 was Ex Order 26. 4B1 ; had diagnoses which included Ex Order 26. 4B1 [redacted].

On 05/16/23 at 3:37 PM, one medication cart on the secured unit was observed to be unattended and unlocked. Licensed Practical Nurse (LPN) 1, to whom the cart was assigned for the shift, was observed in a resident's room providing Ex Order 26. 4B1 . The medication cart was not in LPN1's line of sight. Staff members were observed at the nurses' station engaged in their work and did not have the medication cart in their line of sight. Residents were observed wandering about the unit in close proximity to the medication cart. The Administrator approached the surveyor, confirmed the medication cart was unlocked and unattended, asked staff who was assigned to the cart, and then locked the cart.

During an interview on 05/16/23 at 3:45 PM, LPN 1 confirmed the medication cart was her assigned cart for the current shift and confirmed she had left it unlocked and unattended.

During an interview on 05/18/23 at 6:12 PM, the Director of Nursing (DON) stated her expectations were for the nurses to keep medication carts always locked and secure.

Review of the facility's policy titled "Storage of

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F 761	Continued From page 22 Medications," updated 01/2023, revealed, " . . . Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications . . . Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended . . . "	F 761		
F 801 SS=F	NJAC 8:39-29.4(h) Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by	F 801		6/30/23

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F 801	Continued From page 23 an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of	F 801		

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F 801	Continued From page 24 higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on interview and facility job description review, the facility failed to employ either a full time Registered Dietitian (RD) or a qualified Dietary Manager (DM) to carry out the functions of the food and nutrition service since March 2023. This failure had the potential to affect 115 residents who received food from the kitchen. Findings include: During an interview on 05/16/23 at 9:35 AM, the DM stated she had been employed as the facility's DM since Ex Order 26. 4B1. The DM confirmed that she recently completed the Serv Safe course but was not a Certified Dietary Manager (CDM). The DM stated the facility's Registered Dietitian (RD) was employed on a consultant basis and usually visited the facility once or twice per week.	F 801	1. No residents were directly affected. All residents have the potential to be affected. 2. Dietary Manager and Assistant Dietary Manager educated by Regional Dietary Manager on requirement for Qualified Dietary Staff 483.60(a)(1)(2). 6.15.23 - Dietary Manager enrolled in a certified food manager course and will become a Certified Food Manager. 6.15.23 - Assistant Dietary Manager enrolled in Certified Food Manager course. Facility contracts with a FT, 40 hours/week Registered Dietitian, who will be covering the facility until Dietary Manager completes the CFM course. 3. The administrator and/or their designee, will audit Certified Manager credentials of all Dietary Managers	

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F 801	Continued From page 25 During an interview on 05/19/23 at 2:39 PM, the DM stated she worked as the facility's assistant dietary manager for a year prior to becoming the DM *Ex Order 26. 4B1* ago. The DM confirmed she did not have prior experience working as a director of food and nutrition services in a nursing facility, was not a CDM and was not currently enrolled in a CDM course. The DM stated a full-time RD was not employed at the facility since she started working as the DM in *Ex Order 26. 4B1*. During an interview on 05/19/23 at 2:50 PM, the Regional Dietary Manager confirmed the facility's DM was not currently certified but thought a waiver was still in effect that allowed a non-certified DM additional time to become a CDM in the State of New Jersey. During an interview on 05/19/23 at 3:20 PM, the facility's Registered Dietitian (RD) confirmed she was not a full-time employee and worked at the facility as a consultant. The consultant RD stated she visited the facility once or twice a week and provided clinical coverage for the resident population. Review of the facility's undated job description entitled "Food Services Director," revealed, " . . . Education & Qualifications ... Must provide documentation of registry/certificate upon application for position . . . " NJAC 8:39-17.1(a)	F 801	employed at the facility 1x per month x3 months. 4. The Administrator and/or their designee will provide monthly audits to the QAPI committee monthly, x3 months, to ensure compliance.	
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b)	F 802		6/30/23

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F 802	Continued From page 26 §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of Resident Council meeting minutes, and facility policy review, the facility failed to have sufficient dietary staff to assure resident meals were served as scheduled. The failure had the potential to affect 115 residents who consumed meals prepared from the facility's kitchen. Findings include: 1. Review of the Resident Council meeting minutes, dated 04/25/23 and provided by the facility, revealed the following concern, " . . . lunch and dinner has been served late . . . " The staff response was " . . . lunch trucks delivered at 11:30 AM and 4:30 PM . . . dietary must notify staff on the unit floor when trucks arrived . . . "	F 802	1. All residents could have the potential to be affected. 2. Dietary food cart Delivery Times Schedule updated to reflect new delivery times. Residents were consulted and approved the updated schedule. Food carts delivered to the floor by dietary staff will have a unit clerk and/or licensed nurse sign off that food cart was delivered, with delivery time noted on receipt. Sequence of food carts adjusted to accommodate residents who attend activities. West Unit Dining Room is open for lunch and dinner. 3. Education for all Dietary Staff, Unit Clerks and Licensed Nurses will be conducted by the Dietary Director and/or their designee regarding updated food cart delivery schedule and the sign-off	

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F 802	Continued From page 27 2. A group interview was conducted on 05/17/23 at 1:00 PM with seven residents whom the facility identified as reliable historians. During the meeting, seven of the seven residents (Residents (R) 31, R36, R39, R72, R84, R89, and R91) voiced complaints about meals being served later than scheduled. R84 stated "*Ex Order 26. 4B1* [redacted]." R91 stated "*Ex Order 26. 4B1* [redacted]" The other six residents in attendance at the meeting confirmed R91's statement. The residents explained when their evening meal trays were delivered later than scheduled, they ran the risk of missing their scheduled evening activities (which were scheduled Monday to Friday, beginning at 6:00 PM) which they really enjoyed and did not want to miss. 3. Review of R34's electronic medical record (EMR) revealed a quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of *Ex Order 26. 4B1* located under the "MDS" tab. The assessment revealed a *Ex Order 26. 4B1* [redacted] score of [redacted] of 15 for R34, which indicated the resident was *Ex Order 26. 4B1* [redacted]. During an interview on 5/17/23 at 5:25 PM, R34, who resided on the facility's West hallway, stated she was upset because her evening meal had not been served and her evening meal the day before was not served until 5:56 PM. R34 stated [redacted]. R34 explained her meals were previously served on time, but with the current kitchen staff she could	F 802	process upon cart delivery to each unit. Dietary Director and/or designee will audit timeliness food delivery carts 1x daily at the lunch and dinner meals x4 weeks and 1x weekly thereafter x2 months. 4. The Dietary Manager and/or their designee will provide all daily and weekly audits to the QAPI committee monthly x3 months to ensure compliance.	

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F 802	Continued From page 28 never tell how late her meals would be served. On 05/17/23 at 5:36 PM, the last West hallway meal cart was delivered to the hallway. This was 21 minutes later than the scheduled time of 5:15 PM noted on the facility's meal delivery schedule. On 05/17/23 at 5:39 PM, R34 was observed receiving her evening meal. 4. In response to resident complaints about meals being served later than scheduled, a test tray was requested to be sent to the facility's West hallway, the last scheduled resident hallway meal cart to be delivered, during the breakfast meal on 05/19/23. Observation revealed the meal cart, which contained the test tray, left the kitchen at 8:47 AM. The cart was delivered to the West hallway by the Dietary Manager (DM) at 8:48 AM, which was 23 minutes later than the scheduled delivery time of 8:25 AM noted on the facility's meal delivery schedule. 5. During an interview on 05/17/23 at 6:50 PM, the DM confirmed the resident evening meal on 05/17/23 was served later than scheduled. The DM stated the facility's current meal schedule was developed when the facility had a census of 80 to 90 residents. The DM explained that the current facility census was 134 residents, so it took the kitchen staff longer to prepare and serve meals which caused resident meals to be served later than scheduled. Review of the facility's undated policy titled, "Food Truck Delivery Schedule," revealed, the resident meals were scheduled to be delivered to facility units at the following times:	F 802		

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F 802	Continued From page 29 Ventilator Unit: Breakfast 7:45 AM, Lunch 11:40 AM, Dinner 4:40 PM South Unit: Breakfast 8:20 AM, Lunch 11:45 AM, Dinner 4:45 PM Low North Unit: Breakfast 8:10 AM, Lunch 11:50 PM, Dinner 4:50 PM West Unit: Breakfast 8:05 AM, Lunch 11:55 AM, Dinner 4:55 PM Mid North Unit: Breakfast 8:10 AM, Lunch 12:15 PM, Dinner 5:00 PM South Unit: Breakfast 8:20 AM, Lunch 12:15 PM, Dinner 5:05 PM High North Unit: Breakfast 7:45 AM, Lunch 12:10 PM, Dinner 5:10 PM West Unit: Breakfast 8:25 AM, Lunch 12:15 PM, Dinner 5:15 PM	F 802		
F 804 SS=E	NJAC 8:39-17.3(b)(c) Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, tasting of foods on a requested test tray, record review, review of Resident Council meeting minutes, and facility policy review, the facility failed to serve food that was palatable and hot to eleven of eleven	F 804	1. All residents have the potential to be affected. 2. The Regional Dietary Manager and Dietary Manager immediately provided education to all dietary staff regarding	6/30/23

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F 804	Continued From page 30 residents (Resident (R) 33, R34, R67, R111, R31, R36, R39, R72, R84, R89, and R91) reviewed for food palatability. This failure had the potential to affect 115 residents who consumed food prepared from the facility's kitchen. Findings include: 1. Review of R33's electronic medical record (EMR) revealed a quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of Ex Order 26. 4B1 located under the "MDS" tab. The assessment recorded a 'Ex Order 26. 4B1 [redacted] " score of [redacted] of 15 for R33, which indicated the resident was Ex Order 26. 4B1 [redacted]. During an interview on 05/16/23 at 10:40 AM, R33 stated the food served at meals was not hot. R33 specified the food served at the breakfast meal was cold more often than the other meals. 2. Review of the electronic face sheet for R34, located under the "Profile" tab of the EMR, revealed R34 was admitted to the facility on Ex Order 26. 4B1 with diagnoses that included Ex Order 26. 4B1 [redacted]. Review of R34's "Care Plan," located under the "Care Plan" tab of the EMR revealed R34 had a diagnosis of depression and was at risk for variations in intake/appetite and at risk for Ex Order 26. 4B [redacted]. During an interview on 05/16/23 at 12:21 PM, R34 stated that she had complained about the food and spoken with the Ombudsman, but the food had gotten worse. R34 stated the food was	F 804	proper temperatures for hot and cold foods and beverages and palatability of meal. The heating system being used is a dome based: hot pellet, heated plate, and dome cover. 3. Breakfast pancakes are now prepared homemade and bulk syrup is heated up to ensure a better temperature. Monkey dishes are now being used to separate items such as muffins and cottage cheese. Cooks have been educated on flavor and palpability of meals. Cooks, along with Dietary Director and/or their designee, will taste items to ensure good flavor and palatability. Food temperatures will be taken 30 minutes before every service and recorded. Dietary Director and/or their designee will audit test trays 3x a week x4 weeks and 1x per week per month x2 months. Dietary Director to schedule/conduct monthly Resident Food Committee to determine food is getting better, staying the same or getting worse, and to act upon all reasonable suggestions made by the Resident Food Committee with monthly follow-up at the Resident Council meeting. 4. The Food Service Director and/or their designee will provide all daily and weekly audits, and monthly Resident Food Committee minutes, to the QAPI committee monthly x3 months to ensure compliance.	

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F 804	Continued From page 31	F 804		

bland and cold. R34 stated the facility had previously used closed metal carts to deliver the food trays, but now they used small, open carts that were not capable of holding all the trays brought to the hall at one time. She stated the food was often late and, on most day, because activities began at 6:00 PM, she had to cut her dinner short in order to go to activities.

During an observation on 05/16/23 at 12:26 PM through 12:57 PM, the lunch cart was observed arriving late and without a covering to help maintain food temperatures.

3. Review of R67's EMR revealed a quarterly MDS with an ARD of Ex Order 26. 4B1 located under the "MDS" tab. The assessment recorded a Ex Order 26. 4 score of Ex Ord of 15 for R67, which indicated the resident was *Ex Order 26. 4B1*.

During an interview on 05/16/23 at 12:25 PM, R67 stated the food served at meals was often cold when she received meals in her room. R67 specified she was often served cold pancakes at breakfast.

4. Review of R111's EMR revealed a significant change MDS with an ARD of Ex Order 26. 4B1 located under the "MDS" tab. The assessment recorded a Ex Order 26. 4 score of Ex Ord of 15 for R111, which indicated the resident was *Ex Order 26. 4B1*.

Review of R111's current physician's orders, located under the "Orders" tab of the EMR, revealed an order for a *Ex Order 26. 4B1* .

During an interview on 05/16/23 at 2:17 PM, R111 stated the food served at meals was too salty and

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F 804	Continued From page 32	F 804		

when she was served a muffin and cottage cheese on the same plate, her muffin was soggy.

5. In response to resident complaints about food, a test tray was requested to be sent to the facility's West hallway during the breakfast meal on 05/19/23. Observation revealed before the meal tray cart, which contained the test tray, left the kitchen at 8:47 AM, the food temperatures were at acceptable levels of 140 degrees Fahrenheit and above. The meal trays were placed on an open tray cart with no heating element and were delivered to the West hallway.

The last resident breakfast tray was served on the West hallway on 05/19/23 at 8:55 AM. At this time, the food on the test tray was sampled in the presence of the facility's Dietary Manager (DM). Tasting of the food revealed the following:

a. The scrambled eggs served on the test tray were warm when tasted. The DM also tasted the scrambled eggs and confirmed the eggs were not hot.
b. The waffles served on the test tray were warm when tasted. The DM also tasted the waffles and confirmed the waffles were not hot.

During an interview on 05/19/23 at 9:00 AM, the DM stated residents should be served hot food at meals.

6. On 05/17/23 at 1:00 PM, a Resident Council Meeting was conducted with seven residents (R31, R36, R39, R72, R84, R89, and R91) including the Resident Council President and the Resident Council Vice President. The residents present regularly attend the facility's monthly Resident Council meetings. The residents were

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F 804	Continued From page 33 asked about their dining experiences at the facility. The following concerns were expressed: R84 said, "The food is always cold, tastes terrible, and it's late being delivered." R72 said she "asked for an orange for three days, was told the kitchen would get me an orange but never did." R72 said the kitchen always "runs out of everything." R36 said she "has requested more varieties in the food, specifically actual ham versus processed lunchmeat that has too much salt." "That's not good for us, so much salt." R39 asked for "butter not margarine." R36 said they "have been told the dietary budget was cut which is why they cannot always accommodate all their requests." R91 said the "meal trays are brought out on a cart, but they sit there waiting for staff to deliver them and then the food is cold by the time it gets to us in our rooms." All seven residents confirmed the cold food statement made by R91. The residents were asked if they utilized the main dining room for meals. The group said they used to go to the dining room until COVID. Since then, they have been eating in their rooms. The residents said when the trays are late to be delivered to them, they run the risk of missing their evening activities which they really like and do not want to miss. During an interview on 05/19/23 at 1:05 PM, the Ombudsman said "Cold food has been an issue." The Ombudsman said the residents used to eat in the main dining room which is much closer to the kitchen which would keep the food hotter than carting it to each wing. The Ombudsman said the facility used to have insulated carts to deliver the	F 804		

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F 804	Continued From page 34 meal trays, but she does not know why they changed to the open carts, "I'm sure the food is cold." 7. Review of Resident Council Minutes, provided by the facility, revealed the following: On 01/26/23, a concern was noted as "need more food choices." The staff response was "will add more choices." On 02/23/23, a concern was noted as "food is cold when delivered to rooms." The staff response was "all food leaves the kitchen at correct temperatures." On 04/25/23 a concern was noted as "lunch and dinner has been served late." The staff response was "lunch trucks delivered at 11:30 AM and 4:30 PM . . . dietary must notify staff on the unit floor when trucks arrived." Review of the facility's policy titled, "Food Preparation," dated 02/07/22, revealed, " . . . The chef or cook and dining services director are responsible for tasting all prepared food in order to judge the quality of the finished product . . . "	F 804		
F 809 SS=E	NJAC 8:39-17.4(a)2 NJAC 8:39-17.4(e) Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in	F 809		6/30/23

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(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 809	Continued From page 35 the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's meal schedule, the facility failed to have no more than 14 hours between the resident evening meal and breakfast meal the following day. This failure had the potential to affect 115 residents who received meals from the facility's kitchen. Findings include: Review of the facility's undated policy titled, "Food Truck Delivery Schedule," revealed the following scheduled resident evening and breakfast meal delivery times for each unit and the total time scheduled between these two meals that exceeded the 14-hour time frame requirement: Ventilator Unit: Dinner 4:40 PM and Breakfast 7:45 AM- A total of 15 hours and 5 minutes scheduled between the resident evening meal and following breakfast meal.	F 809	1. All residents have the potential to be affected. 2. The amount of nutritious and bulk H.S. snacks in the evening were increased to accommodate all the residents. The snacks include the following: a variety of meat sandwiches, peanut butter and jelly, soft sandwiches for mechanically altered diets, pudding, apple sauce, fruit, crackers, ice cream and cold cereal. 3. Unit pantries are stocked daily to ensure product 24/7. Dietary Manager educated all dietary staff regarding the distribution and maintaining proper par levels of H.S. snacks in the pantries on each Unit. Dietary Manager and/or their designee will audit all unit pantry snack bins, refrigerators, and freezers for proper par levels and to ensure snacks are being offered to residents at H.S. 3x per week	

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 05/19/2023

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F 809	Continued From page 36 South Unit cart 1: Dinner 4:45 PM and Breakfast 8:20 AM- A total of 15 hours and 35 minutes scheduled between the resident evening meal and following breakfast meal. Low North Unit: Dinner 4:50 PM and Breakfast 8:10 AM- A total of 15 hours and 20 minutes scheduled between the resident evening meal and following breakfast meal. West Unit cart 1: Dinner 4:55 PM and Breakfast 8:05 AM- A total of 15 hours and 10 minutes scheduled between the resident evening meal and following breakfast meal. Mid North Unit: Dinner 5:00 PM and Breakfast 8:10 AM- A total of 15 hours and 10 minutes scheduled between the resident evening meal and following breakfast meal. South Unit cart 2: Dinner 5:05 PM and Breakfast 8:20 AM- A total of 15 hours and 15 minutes scheduled between the resident evening meal and following breakfast meal. High North Unit: Dinner 5:10 PM and Breakfast 7:45 AM- A total of 14 hours and 35 minutes scheduled between the resident evening meal and following breakfast meal. West Unit cart 2: Dinner 5:15 PM and Breakfast 8:25 AM- A total of 15 hours and 10 minutes was scheduled between the resident evening meal and following breakfast meal. During an interview on 05/17/23 at 6:50 PM, the Dietary Manager (DM) confirmed the resident meal schedule exceeded 14 hours between the	F 809	x4 weeks and then 1x per week x2 months. 4. The Food Service Director and/or their designee will provide all daily and weekly audits to the QAPI committee monthly x3 months to ensure compliance.	

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F 809	Continued From page 37 resident evening meal and breakfast meal the following day. The DM stated she was not aware there could be no more than 14 hours between the resident evening meal and breakfast meal. The DM stated the facility offered bedtime snacks but did not have resident agreement to exceed the 14-hour time frame between serving the resident evening meal and the resident breakfast meal the following day. Observation of the evening meal on 05/18/23 revealed the West unit's second meal cart was delivered to the hallway at 5:15 PM. Observation of the breakfast meal on 05/19/23 revealed the West unit's second meal cart was delivered to the hallway at 8:48 AM. A total of 15 hours and 33 minutes elapsed between the 05/18/23 resident evening meal being delivered to the West hallway and the 05/19/23 resident breakfast meal being delivered to the hallway. NJAC 8:39-17.2(f)1 NJAC 8:39-17.4(b)	F 809		
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	F 812		6/30/23

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	315185	A. BUILDING _____ B. WING _____	C 05/19/2023

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F 812	Continued From page 38 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 facility policy review, the facility failed to keep the kitchen's milk refrigerator, electric slicer, three kitchen drawers, and canned food storage racks clean and sanitized and failed to date opened bread products and discard creamed soup and hot dog buns with expired use by dates. This failure had the potential to affect 115 residents who consumed food prepared from the facility's kitchen. Findings include: 1. Observation during the initial kitchen inspection on 05/16/23 from 9:45 AM to 10:30 AM, with the Dietary Manager (DM) present, revealed the following unclean food preparation and storage equipment: a. The interior of the kitchen's milk refrigerator had a very strong odor of soured milk. Observation under the crates of milk stored inside this refrigerator revealed a brownish and white colored liquid pooled in the bottom of refrigerator that smelled like soured milk. b. The kitchen's electric slicer, covered and ready for use, was unclean with a greasy residue and food debris on its blade and base.	F 812	1. All residents have the potential to be affected. 2. 5.16.23 Milk was removed from the milk box and cleaned by dietary staff. Dietary Manager took apart the food slicer and had it cleaned and sanitized. Education provided on proper cleanliness and storage of slicer. Utensils were removed from drawers and cleaned. Utensils are no longer stored in drawers. The can rack was emptied and cleaned by staff immediately after the walk through. Outdated bread and soup were immediately discarded. 3. Regional Dietary Manager and Dietary Manager educated all dietary staff in proper dating, labeling, and storage of food, the First-in & First-out (FIFO) system, and how to properly clean, sanitize and store kitchen equipment and service ware. Dietary Manager and/or their designee will complete 3x weekly audits x4 weeks and then 1x per week audits x2 months which will include the following: food safety inspections, cleanliness of refrigerated food storage units, kitchen equipment cleaning and storage, and service ware cleaning and storage.	

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F 812	Continued From page 39 c. Three kitchen drawers, with food preparation equipment that included scoops, spatulas, serving spoons, and tongs stored in them, were unclean with greasy residues and food debris. When the interior of each drawer was wiped with a wet paper towel a black residue was observed on the towel. d. The kitchen's two large metal can storage racks, with cans stored on them, were unclean. Accumulated dirt, dust and food debris were on the rack's metal tracks where cans were stored. During an interview on 05/16/23 at 10:30 AM, the DM confirmed the kitchen's milk refrigerator, electric slicer, three drawers housing food preparation equipment and two large can storage racks were not clean. The DM stated the kitchen equipment should be kept cleaned by staff. The DM explained that she was not sure when the kitchen's two large can storage racks were last cleaned because they were not on the kitchen's current cleaning schedule. 2. Observation during the initial kitchen inspection on 05/16/23 from 9:45 AM to 10:30 AM, with the DM present, revealed the following concerns with food storage: a. Observation of the kitchen's bread storage shelves revealed an opened and undated package of rye bread, an opened and undated package of cinnamon raisin bread and two packages of hot dog buns with expired use by dates of 05/11/23. b. Observation of the kitchen's walk-in refrigerator revealed a large plastic container with a	F 812	4. The Food Service Director and/or their designee will provide all daily and weekly audits to the QAPI committee monthly x3 months to ensure compliance.	

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F 812	Continued From page 40 commercial label that indicated it contained hard boiled eggs. The exterior of the container also had a label with a use by date of 05/11/23. Observation of the container's contents revealed a congealed food with approximately a half inch of water on top of it. The DM initially identified the congealed food as leftover gravy and later identified it as leftover creamed soup. The DM stated the container should have been correctly labeled with the food stored inside and the leftover creamed soup should have been discarded by staff on 05/11/23. During an interview on 05/16/23 at 10:30 AM, the DM stated staff should discard any food that was not labeled and dated or had an expired use by date. Review of the facility's policy titled, "Cleaning Schedules," dated 02/07/22, revealed, "Policy: The food service staff will maintain the cleanliness and sanitation of the food service areas through compliance with a written, comprehensive, cleaning schedule developed by the Food Service Director (FSD). Procedure: 1. The FSD will determine all cleaning and sanitation tasks needed for the department . . . " Review of the facility's policy titled, "Food Storage," dated 02/07/22, revealed, " . . . All leftover food for storage in refrigeration is put in a storage container and completely covered with plastic or foil wrap, marked with the same name of item, dated and given a use by date to be use within 72 hours . . . " Review of the facility's undated policy titled, "Dry Food Policy," revealed, " . . . Immediately after delivery all products will be dated for proper	F 812		

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F 812	Continued From page 41 rotation . . . Keep product clearly labeled and in its original packaging . . . " NJAC 8:39-17.2(g) NJAC 8:39-19.7(d)	F 812		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060104	A. BUILDING: _____ B. WING _____	C 05/19/2023

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S 000	Initial Comments Census: 134 Sample Size: 45&5 TYPE OF SURVEY: Recertification and Complaint The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, facility document review, and New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, it was determined that the facility failed to ensure staffing ratios were met. The facility was deficient in certified nursing assistant (CNA) staffing for residents on 14 of 14 days shifts for the 2 weeks of 04/30/2023 - 05/13/2023 and 14 of 14 evening shifts. This deficient practice had the potential to affect all residents.	S 560	1. All Residents in facility have the potential to be affected. 2. The facility continues to actively fill all open CNA (Certified Nursing Assistant) shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Human Resource Director, who was able to reiterate minimum staffing requirements for nursing homes.	6/30/23

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

Electronically Signed — 06/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060104	A. BUILDING: _____ B. WING _____	C 05/19/2023

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S 560	Continued From page 1 Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One certified nurse aide to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each direct staff member shall be signed in to work as a certified nurse aide and shall perform nurse aide duties; and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 14 of 14 evening shifts as follows: -04/30/23 had 10 CNAs for 130 residents on the day shift, required 16 CNAs. -04/30/23 had 5 total staff for 130 residents on	S 560	3. Human Resources Director will focus recruitment and retention strategies as following: identify vacant positions daily and attempt to fill positions with current CNA staff or agency; work diligently with Administrator, Director of Nursing and Corporate Recruiter to advertise, recruit and hire sufficient CNA staff; continue to develop programs to attract Nursing Assistants including sign-on bonuses', shift bonuses, etc.; work with CNA class instructors to identify potential students; promote in-house programs to increase retention of current staff. Human Resources Director and/or their designee will audit the effectiveness of hiring strategies 1x week for 3 months. 4. Human Resources Director and/or Designee will provide statistics to the QAPI committee monthly x3 months. Statistics will include open CNA positions vs. new hires, reporting on successful strategies-to-hire based on percentages, and turnover rates.	

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S 560	Continued From page 2	S 560		

the evening shift, required 13 total staff.
-05/01/23 had 11 CNAs for 130 residents on the day shift, required 16 CNAs.
-05/01/23 had 5 total staff for 130 residents on the evening shift, required 13 total staff.
-05/02/23 had 12 CNAs for 130 residents on the day shift, required 16 CNAs.
-05/02/23 had 5 total staff for 130 residents on the day shift, required 13 total staff.
-05/03/23 had 15 CNAs for 130 residents on the day shift, required 16 CNAs.
-05/03/23 had 5 total staff for 130 residents on the evening shift, required 13 total staff.
-05/04/23 had 15 CNAs for 132 residents on the day shift, required 16 CNAs.
-05/04/23 had 5 total staff for 132 residents on the evening shift, required 13 total staff.
-05/05/23 had 15 CNAs for 132 residents on the day shift, required 16 CNAs.
-05/05/23 had 6 total staff for 132 residents on the day shift, required 16 CNAs.
-05/06/23 had 15 CNAs for 132 residents on the day shift, required 16 CNAs.
-05/06/23 had 5 total staff for 132 residents on the evening shift, required 13 total staff.

-05/07/23 had 10 CNAs for 132 residents on the day shift, required 16 CNAs.
-05/07/23 had 6 total staff for 132 residents on the evening shift, required 13 total staff.
-05/08/23 had 10 CNAs for 132 residents on the day shift, required 16 CNAs.
-05/08/23 had 5 total staff for 132 residents on the evening shift, required 13 total staff.
-05/09/23 had 14 CNAs for 132 residents on the day shift, required 16 CNAs.
-05/09/23 had 6 total staff for 132 residents on the day shift, required 13 total staff.
-05/10/23 had 15 CNAs for 132 residents on the day shift, required 16 CNAs.

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S 560	Continued From page 3 -05/10/23 had 7 total staff for 132 residents on the evening shift, required 13 total staff. -05/11/23 had 12 CNAs for 132 residents on the day shift, required 16 CNAs. -05/11/23 had 6 total staff for 132 residents on the evening shift, required 13 total staff. -05/12/23 had 10 CNAs for 132 residents on the day shift, required 16 CNAs. -05/12/23 had 5 total staff for 132 residents on the evening shift, required 13 total staff. -05/13/23 had 12 CNAs for 134 residents on the day shift, required 17 CNAs. -05/13/23 had 7 total staff for 134 residents on the evening shift, required 13 total staff.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315185 Y1	A. Building B. Wing Y2	7/6/2023 Y3

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 F0550	Correction	ID Prefix F0576	Correction	ID Prefix F0584	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.10(g)(6)-(9)	Completed	Reg. # 483.10(i)(1)-(7)	Completed
LSC	06/30/2023	LSC	06/30/2023	LSC	06/30/2023
ID Prefix F0689	Correction	ID Prefix F0692	Correction	ID Prefix F0761	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed
LSC	06/30/2023	LSC	06/30/2023	LSC	06/30/2023
ID Prefix F0801	Correction	ID Prefix F0802	Correction	ID Prefix F0804	Correction
Reg. # 483.60(a)(1)(2)	Completed	Reg. # 483.60(a)(3)(b)	Completed	Reg. # 483.60(d)(1)(2)	Completed
LSC	06/30/2023	LSC	06/30/2023	LSC	06/30/2023
ID Prefix F0809	Correction	ID Prefix F0812	Correction	ID Prefix F0921	Correction
Reg. # 483.60(f)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.90(i)	Completed
LSC	06/30/2023	LSC	06/30/2023	LSC	06/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
5/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315185 Y1	A. Building B. Wing Y2	7/6/2023 Y3

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 06/30/2023	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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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 5/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060104 Y1	A. Building B. Wing Y2	7/6/2023 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 06/30/2023	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	ID Prefix Reg. # LSC	Correction Completed
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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 5/19/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315185	A. BUILDING **01** B. WING _____	**05/19/2023**

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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 05/16/2023. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 05/16/2023 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Linwood is a one story building which was built in 1963. It is composed of Type II protected construction. The facility is divided into ten smoke zones. The current occupied beds are 135 of 170.	K 000		
K 291 SS=E	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure battery-powered emergency lighting was provided at the emergency generator transfer switches in accordance with NFPA 110	K 291	1. All Residents in facility have the potential to be affected. 2. Emergency battery back-up lighting will be installed by facility electrical	6/30/23

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

Electronically Signed | 06/16/2023

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) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315185	A. BUILDING **01** B. WING _____	**05/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 291	Continued From page 1 Standard for Emergency and Standby Power Systems (2010 edition) Section 7.3. This deficient practice had the potential to affect 83 residents. Findings include: An observation on 05/16/23 at 1:45 PM revealed battery-powered emergency lighting was not present at the emergency generator transfer switch for the North Wing. An observation on 05/16/23 at 2:02 PM revealed battery-powered emergency lighting was not present at the emergency generator transfer switch for the East Wing and Vent Unit. During an interview at the time of the observations, the Maintenance Director confirmed the emergency lighting was not present and stated the Regional Manager had conducted an inspection the week prior and informed him they needed battery-powered emergency lighting at the generator transfer switches. He stated they had not had an opportunity to put them in the areas. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	contractor for 2 generator transfer switches. 3. Regional Maintenance Director educated facility Maintenance Director on the testing of the emergency lighting. The Maintenance Director and/or designee will check/audit the battery back-up lighting for 30 seconds 1x monthly x3 months to comply with NFPA 110 Standard for Emergency and Standby Power Systems. 4. The Maintenance Director and/or their designee will provide all monthly audits to the QAPI committee monthly x3 months to ensure compliance.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		6/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315185	A. BUILDING **01** B. WING _____	**05/19/2023**

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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K 345	Continued From page 2 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure systems and associated equipment for the fire alarm system were tested on a semi-annual basis in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 edition), Table 14.4.2.2. This deficient practice had the potential to affect 135 residents. Findings include: A review of fire inspection reports from the "State Binder," dated January 2022 - May 2023, provided by the Maintenance Director revealed the fire alarm system had not been tested on a semi-annual basis. Inspections were conducted on 06/10/22 and 02/27/23. During an interview on 05/16/23 at 4:00 PM, the Maintenance Director confirmed the inspections and tests had not been completed on a semi-annual basis. He stated he had been in the position for a few weeks and the former Maintenance Director might have filed other inspections in a different location. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 345	1. All Residents in facility have the potential to be affected. 2. The facility has a contract with a licensed vendor for semiannual fire alarm testing. The vendor was called and reminded of 6-month deadline, but did not get to the building for almost 3 months after it was due. 3. The Regional Maintenance Director provided education to the Maintenance Director regarding the requirement for semi-annual fire alarm testing at the facility and keeping a record of those inspections on file in the facility to comply with NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing must be readily available per 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72. The Maintenance Director and/or designee will audit Preventative Maintenance reports to ensure all fire and smoke alarm testing and inspections are current 1x per week x4 weeks and then 1x per month ongoing. 4. The Maintenance Director and/or their designee will provide all weekly and monthly audits to the QAPI committee monthly x3 months to ensure compliance.	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or	K 363		6/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315185	A. BUILDING **01** B. WING _____	**05/19/2023**

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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K 363	Continued From page 3 hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were	K 363	1. All Residents in facility have the potential to be affected. 2. 6.5.23 - Room 88 Maintenance	

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	315185	A. BUILDING **01** B. WING _____	**05/19/2023**

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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K 363	Continued From page 4 constructed to resist the passage of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) section 19.3.6.3. This deficient practice had the potential to affect 46 residents. Findings include: An observation on 05/16/23 at 3:04 PM revealed the door to Room 88 failed to latch when closed. An observation on 05/16/23 at 3:09 PM revealed the door to Room 106 had a one inch gap between the top of the door and the door frame when the door was closed. An observation on 05/16/23 at 3:25 PM revealed the door to Room 24 failed to latch when closed. During an interview at the time of the observations, the Maintenance Director confirmed the doors did not latch when closed and the one inch gap between the door and the door frame. The Maintenance Director stated the staff utilizes an on-line system for their work orders and the staff does submit work orders when they find corridor doors that do not latch. NJAC 8:39-31.1(c), 31.2(e)	K 363	Director adjusted the door latch, so the door properly closes and latches. The door closes and latches with no penetration for smoke. 6.12.23 - Room 106 Maintenance Director adjusted the door so when the door fully closed there was no gap at the top of the door. 6.5.23 - Room 24 Maintenance Director adjusted the door latch, so the door properly closes and latches. The door closes and latches with no penetration for smoke. 3. The Regional Maintenance Director educated the Maintenance Director regarding corridor doors protecting corridor openings in required enclosures of vertical openings, exits, or hazardous areas to resist the passage of smoke. The Maintenance Director will audit all facility fire-rated corridor doors 1x weekly for 4 weeks and 1x monthly ongoing. 4. The Maintenance Director and/or their designee will provide all weekly and monthly audits to the QAPI committee monthly x3 months to ensure compliance.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct	K 372		6/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315185	A. BUILDING **01** B. WING _____	**05/19/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 372	Continued From page 5 penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke in accordance with NFPA 101 Life Safety Code (2012 edition) Section 8.5.6.1. This deficient practice had the potential to affect 15 residents. Findings include: An observation on 05/16/23 at 12:53 PM revealed the smoke barrier, located above the ceiling tiles adjacent to Room 81, had a four inch sprinkler pipe penetrating a five inch unsealed opening. During an interview at the time of the observation, the Maintenance Director confirmed the unsealed opening and stated he had been in the position as Maintenance Director only a few weeks and had not had the chance to inspect the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372	1. All Residents in facility have the potential to be affected. 2. 6.2.23 - The Maintenance Director sealed the five-inch open penetration above the ceiling tile adjacent to Room 81 with brick and mortar. 3. The Regional Maintenance Director educated the facility Maintenance Director on penetrations to smoke barriers. The Maintenance Director and/or designee will audit all facility ceiling for any penetrations 1x monthly x3 months then annually ongoing or after any ceiling related work is performed. 4. The Maintenance Director and/or their designee will provide all monthly audits to the QAPI committee monthly x3 months to ensure compliance.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room,	K 741		6/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315185	A. BUILDING **01** B. WING _____	**05/19/2023**

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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K 741	Continued From page 6 ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure an ashtray of noncombustible material and safe design and a metal container with a self-closing cover device into which an ashtray could be emptied were readily available to the smoking area in accordance with NFPA 101 Life Safety Code (2012 Edition) section 19.7.4 (5) (6). This deficient practice had the potential to affect four residents who utilized the smoking area. Findings include: An observation on 05/16/23 at 2:47 PM revealed	K 741	1. All Residents in facility have the potential to be affected. 2. 6.2.23 - The maintenance director purchased a new noncombustible material ashtray and metal container with a self-closing lid for used for emptying ashtrays. The ashtray and metal container were put into use immediately and the old ashtray was disposed of. 3. Regional Maintenance Director educated facility Maintenance Director regarding the need for only using ashtrays of non-combustible material and safe design and metal containers with	

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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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K 741	Continued From page 7 the smoking area had a freestanding plastic cigarette butt receptacle and did not have an ashtray of noncombustible material and a metal self-closing container. During an interview at the time of the observation, the Maintenance Director confirmed there was not an ashtray of noncombustible material and a metal container with a self-closing cover. He stated he did not know they were required in the smoking area. NJAC 8:39-31.2(e), 31.6(e)	K 741	self-closing covered devices into which ashtrays can be emptied shall be readily available in all areas where smoking is permitted. The Maintenance Director will audit for proper use of approved ashtray and metal container by smokers 3x per week x4 weeks and then 1x monthly for 2 months and ongoing as needed. 4. The Maintenance Director and/or their designee will provide all weekly and monthly audits to the QAPI committee monthly x3 months to ensure compliance.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315185 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/6/2023 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0291	06/30/2023	LSC K0345	06/30/2023	LSC K0363	06/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0372	06/30/2023	LSC K0741	06/30/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
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FOLLOWUP TO SURVEY COMPLETED ON	
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