PRINTED: 05/07/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315185	B. WING _			1	C / <b>29/2023</b>
	ROVIDER OR SUPPLIER	LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		11 NEW ROAD AND CENTRAL AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU			(X5) COMPLETION DATE
F 000	0 INITIAL COMMENTS		F	000			
		202, NJ159616, NJ165150, 1, NJ160394, NJ169450					
	CENSUS: 138						
	SAMPLE SIZE: 14						
	THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.						
F 677 SS=D		or Dependent Residents	F	677			1/26/24
	out activities of daily services to maintain opersonal and oral hyd	ent who is unable to carry living receives the necessary good nutrition, grooming, and giene; is not met as evidenced					
	Complaint #: NJ0016	60150			Residents affected by deficient practic	e:	
	and review of facility was determined that	n, interview, record review, provided documentation, it the facility failed to ensure nce care was provided to			The facility failed to ensure that proper Ex.Order 26.4(b)(1) was provided to dependent residents. This deficient practice was identified for 2 of 3 reside (Resident #13, and #14) observed for Ex.Order 26.4(b)(1)		
	residents (Resident #	e was identified for 2 of 3 f13, and #14) observed for d was evidenced by the			Identify those individuals who could be affected by the deficient practice:  " All incontinent residents have the	e	
		AM, the surveyor ified Nursing Assistants			potential to be affected by the deficient practice.		(Ve) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

**Electronically Signed** 01/12/2024

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  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		315185	B. WING			12/	29/2023
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT LINWOOD, I	ıc		20	01 NEW ROAD AND CENTRAL AVE		
OOMI LLI	L OAKL AT LINWOOD, I			L	INWOOD, NJ 08221		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	residents who were in being dependent on a for incontinence care and CNA #3 entered Resident #13 was in I gown. At that time, the permission for the sure Ex. Order 26.4(b)(1) CNA opened that underneath. The this time CNA #3 informed the reason this residents should not be the reason this resident #14 in bed. dry, and no odor was resident #14 in bed. dry, and no odor was resident granted permobserved an Ex. Order 26.4(b)(stated that residents should use the condition of the thin the property of the property of the property of the property of the condition of the thin the property of t	incontinence tour on the Unit. Three random dentified by the CNAs as staff for care, were observed an Surveyor #1, Surveyor #2, Resident #13's room. Sed wearing a hospital style the resident granted reveyors to observe his/her surveyor #1 observed an oblied to the resident. The exposing an additional addition and the surveyors that the exposing an additional addition and the surveyors that the exposition and the surveyor #1 and the sence of CNA #4 observed Resident #14's sheets were discovered. At that time, the exposition for surveyors to the exposition of the resident's exposition and the resident and the resident in the exposition of the surveyor interviewed and the surveyor interview	F	677	"The residents affected (Resident # and #14) were monitored for any adver effects of the deficient practice with nor noted.  What corrective action will be accomplished for those residents affect by the deficient practice:  "Resident #s 13 and 14	se ne ted ted ted ted ted ted ted ted ted te	
	nursing unit have x.or	der <sup>26.4(b)(1)</sup> and require staff two hours. LPN #3 stated			· ·		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL			(X3) DATE SURVEY COMPLETED	
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		315185	B. WING			12/	29/2023
	ROVIDER OR SUPPLIER FE CARE AT LINWOOD,	LLC		2	TREET ADDRESS, CITY, STATE, ZIP CODE  101 NEW ROAD AND CENTRAL AVE  LINWOOD, NJ 08221		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	disorders.  On 12/29 at 8:25 AM the Registered Nurse who stated residents on residents on residents of and stated, "I'm apparangement." The RN/could be a cause as that the CNA's receive better."  On 12/29/23 at 8:40 the Director of Nursin incontinent residents two hours, and if they should be check DON stated resident diapered, stating "we cause skin breakdow school" CNA's might "not acceptable."  According to the Adn had diagnoses that in to: Ex.Order 26.4(  Review of Resident of Data Set (MDS), an facilitate the manage according to the Adn that they should be checked by the second of 15, which indicate the manage according to the Adn that Set (MDS), and facilitate the manage according to the Adn that Set (MDS), and facilitate the manage according to the Adn that Set (MDS), and facilitate the manage according to the Adn that Reside and the second of 15, which indicate the manage according to the Adn that Reside and the second of 15, which indicate the manage according to the Adn that Reside and the second of 15, which indicate the manage according to the Adn that Reside and the second of 15, which indicate the manage according to the Adn that Reside and the second of 15, which indicate the manage according to the Adn that Reside and the second of 15, which indicate the manage according to the Adn that Reside and the second of 15, which indicate the manage according to the Adn that Reside and the second of 15, which indicate the manage according to the Adn that the second of 15, which indicate the manage according to the Adn that the second of 15, which indicate the manage according to the Adn that the second of 15, which indicate the manage according to the Adn that the second of 15, which indicate the manage according to the Adn that the second of 15, which indicate the manage according to the Adn that the second of 15 and	dents as it could cause skin  I, the surveyor interviewed E Unit Manager (RN/UM #1), "should not be er stated, applying build cause skin breakdown, alled, I don't know what UM stated that short staffing to why this occurred, and we education and "know  AM, the surveyor interviewed and (DON), who stated should be checked every y were a "heavy wetter" then ked more frequently. The se should never be double et don't practice that, it can yn." The DON stated that "old "double diaper", and it is  mission Record, Resident #13 ancluded, but were not limited (b)(1)  #13's Quarterly Minimum assessment tool used to the resident had a Brief Status (BIMS) score did that the resident had (1) The MDS further	F	677			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315185	B. WING		1	C / <b>29/2023</b>
NAME OF PE	ROVIDER OR SUPPLIER		l	STREET ADDRESS, CITY, STATE, ZIP CODE	12	23/2023
COMPLET	E CARE AT LINWOOD, I	TC	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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		BE	(X5) COMPLETION DATE
F 690 SS=D	Review of Resident # revealed score of out of 15, v resident had Ex.Order 26.4(b)(1)  Review of the facility's (ADLs)" policy (Update following:  "Appropriate care and for residents who are independently, with the and in accordance wie appropriate support a a. hygiene (bathing, ocare); b. mobility (transfer alwalking); c. elimination (toileting d. dining (meals and se. communication (sp functional communication).  NJAC 8:39-27.1 (a), 2 Bowel/Bladder Incontraction.	cluded, but were not limited b)(1)  14's Annual MDS, dated the resident had a BIMS which indicated that the er 26.4(b)(1)  The that Resident #14 was  s "Activities of Daily Living ted 1/2023) indicated the days are consent of the resident that the plan of care, including and assistance with: the plan of care, including and assistance with: the plan of care, including and assistance with: the plan of care, including and ambulation, including and ambulation, including g); snacks); and the eech, language, and any action systems)."  27.2 (h) inence, Catheter, UTI		690		1/26/24
	admission receives so maintain continence u					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		315185	B. WING			12/	29/2023
	ROVIDER OR SUPPLIER  TE CARE AT LINWOOD,	LLC		20	TREET ADDRESS, CITY, STATE, ZIP CODE  11 NEW ROAD AND CENTRAL AVE  INWOOD, NJ 08221		
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ON SHOULD BE COMPLETION E APPROPRIATE DATE		
F 690	not possible to maintal §483.25(e)(2)For a reincontinence, based comprehensive asserensure that- (i) A resident who entindwelling catheter is resident's clinical concatheterization was not (ii) A resident who entindwelling catheter or is assessed for remo as possible unless the demonstrates that call (iii) A resident who is receives appropriate prevent urinary tractic continence to the ext §483.25(e)(3) For a reincontinence, based comprehensive asserensure that a resident receives appropriate restore as much norm possible.  This REQUIREMENT by:  Compliant Number:  Based on observation review, it was determined indwelling uniplaced inside the blace.	esident with urinary on the resident's sament, the facility must ters the facility without an not catheterized unless the idition demonstrates that secessary; ters the facility with an authorized same subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible.  esident with fecal on the resident's sament, the facility must at who is incontinent of bowel treatment and services to nal bowel function as	F	690	Residents affected by deficient practic  The facility failed to provide   care in a manner to prevent  n. This deficient  practice was identified for 1 of 3 reside  (Resident #6) reviewed for EX.Order 26.4(b)(1)	<sub>26.476</sub> nts	

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		315185	B. WING			1	C	
NAME OF P	ROVIDER OR SUPPLIER	0.0.00			TREET ADDRESS, CITY, STATE, ZIP CODE	121	29/2023	
					01 NEW ROAD AND CENTRAL AVE			
COMPLET	E CARE AT LINWOOD,	LLC		LINWOOD, NJ 08221				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 690	Continued From page	e 5	F	690				
		e was identified for 1 of 3			and Ex.Order 26.4(b)(1).			
	residents (Resident #							
	evidenced by the follo	and was owing:			Identify those individuals who could be affected by the deficient practice:	3		
	According to the Adm	ission Record, Resident #6			" All residents with indwelling urinar	γ		
	was admitted to the fa	acility with diagnoses which			catheters have the potential to be affect			
	included but not limite	ed to: Ex.Order 26.4(b)(1)			by the deficient practice.			
					" The resident affected (#6) was a discharged resident.			
					discharged resident.			
					What corrective action will be			
					accomplished for those residents affect	ted		
					by the deficient practice:			
		ission Minimum Data Set			" Resident #6 was a closed record.			
		nt tool, dated <sup>Ex.Order 26.4(b)(1)</sup> ,			" All residents with indwelling urinar	-		
		nt #6's cognitive skills were			catheters were audited to ensure foley			
	Ex.Order 26.4(b)(1), an	eview revealed active			catheter care orders were in place and care plans were reviewed and updated			
	diagnosis of Ex.Ord				" All Licensed nursing staff re-education			
	3				on facility policy for Catheter Care Urir			
					and the importance of ensuring cathete	∍r		
		cian Order Summary Report,			care orders are in place.			
	orders for Resident #	ealed the following physician 6: "Patient has <sup>Ex.Order 26.4(b)(1)</sup>			Measures or systemic changes to ensi	ıre		
	orders for resident #	o. Tation has			that the deficiencies will not recur:	al C		
		every shift for						
	Ex.Order 26.4(b)				" Director of Nursing/designee to			
	every sh	ift."			conduct compliance audits of 8 randon			
	A review of Resident	#6's comprehensive care			residents with Indwelling urinary cathe initiated.	lers		
		plan focus: "Resident #6 has			" The duration of all audits will cons	ist		
	Ex.Order 26.4(b)	. Date			of completion three times weekly x4	-		
	Initiated: Ex.Order 26.4(b)(1).	Care planned interventions			weeks then three-times monthly x2			
		nt will be/remain free from			months. Results of audits will be			
	Ex.Order 26.4(b)(1)	through review date. Date			reviewed at the Monthly Quality			
	Initiated: Ex.Order 26.4(b)(1) s/sx (signs/symptoms	The resident will show no			Assurance Meeting and Quarterly at facility QAPI Committee Meeting over	the		
	a/ax (aigna/aympioms				iacinty war i committee inteeting over	II IC	1	

Facility ID: NJ60104

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		315185	B. WING _		4.	C 2/ <b>29/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP C		2/29/2023	
				201 NEW ROAD AND CENTRAL AVE			
COMPLET	E CARE AT LINWOOD, I	LC		LINWOOD, NJ 08221			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 690	Continued From page	÷ 6	F 6	690			
	through review date.  Monitor/document for  Date Initiate  Monitor/record/report s/sx Ex.Order 26.4	Date Initiated: Ex.Order 26.4(b)(1)  Ex.Order 26.4(b)(1)  d: Ex.Order 26.4(b)(1)  to MD (medical doctor) for		duration of the audit proces the results of these audits, be made regarding the nee submission and reporting.	a decision will		
	Ex.Order 26.4(b)(1)						
	A review of October 2022 Medication Administration Record (MAR) revealed the following physician orders:						
	Ex.Order 26.4(b)(1) every	for "Document shift. Include shift. Document shift. Include shift. Document shift. Include shift					
	Order start date of 10 Days." Order was	hours for <sup>exorde</sup> for					
	1 tablet via Ex.Orde	for "Ex.Order 26.4(b)(1) ) Give r 26.4(b)(1) or 3 Days."					
	A review of the Progreat 11:20 AM, revealed Resident #6 had Ex.Order 26.4(b)(	d that on <sup>Ex.Order 26.4(b)(1)</sup> and was started on					

NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT LINWOOD, LLC   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221  (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
STREET ADDRESS, CITY, STATE 2P CODE 20 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221   (X4)   D			315185	15185 B. WING		C 12/29/2023		
FREEIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 690  Continued From page 7  The second of the secon			LLC		201 NEW ROAD AND CENTRAL AVE	12/23/2020		
there were new orders for Resident #6 to discontinue the discontinue that the discontinue the discontinue that the discontinu	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION		
)." When asked if there should be a physician's order for Ex.Order 26.4(b)(1) care, RN/UM #2 stated, "I don't believe we need an order for Ex.Order 26.4(b)(1) care."  On 12/29/2023 at 9:05 AM, the surveyor	F 690	there were new ord discontinue the days for on the control of the	ers for Resident #6 to and start corder 26.4(b)(1) Resident #6 was sible Ex. Order 26.4(b)(1). Into the emergency room to the hospital for diagnosis of the	F 69				

AND DUAN OF CODDECTION			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		315185	B. WING			C
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE  201 NEW ROAD AND CENTRAL AVE  LINWOOD, NJ 08221	1 -	12/29/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 690	conducted an intervie Nursing (DON). The I be a physician's orde The order will show u what does Ex.Order 26 said it includes manamonitoring it for Ex.Order 26.4(b)(III) care resident is at risk for and/or trauma."  The Surveyor reviewe and procedure: "Cath revised date: August "Purpose: The purpos prevent urinary cathe complications, including The following was reviewed. The following was reviewed. The surveyor reviewed at the following was reviewed. The following information: The following information: The following information: The date and time given.  5. Any problems note junction during perine following perines.	w with the Director of DON stated, "there should of for a care." When asked to the care. When asked to the care. When asked to the care. When asked to the care care, Urinary and the care. The DON then stated is not completed the care. Urinary asked to the care, Urinary ask conder 26.4(b)(1).  The DON then stated is not completed the care, Urinary ask conder 26.4(b)(1).  The DON then stated is not completed the care the care, Urinary ask conder 26.4(b)(1).  The DON then stated is not completed the care the care the care that the care is to the care associated and urinary tract infections." It was a care the care that the care around the care that the care around the care that the care and rinse the care that the care and rinse the care and the care that the care and rinse the care and under the steps in the care around the care and rinse the care that the care that the care care that the care t	F 69			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '		(X3) DATE SURVEY COMPLETED
	315185	B. WING		C 12/29/2023
	LLC	:	201 NEW ROAD AND CENTRAL AVE	1
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
Continued From page	e 9	F 690		
		F 725	;	1/26/24
The facility must have the appropriate comp provide nursing and resident safety and a practicable physical, well-being of each reresident assessments and considering the reliagnoses of the facil accordance with the factor at §483.70(e).  §483.35(a)(1) The factor by sufficient numbers types of personnel or nursing care to all resident care plans: (i) Except when waive this section, licensed (ii) Other nursing personnel or nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by:	e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in facility assessment required cility must provide services of each of the following in a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not is.		Residents affected by deficient practic	ce:
Based on observation	n, interview, and review of		were available to: Provide timely and	
	ROVIDER OR SUPPLIER  SUMMARY ST (EACH DEFICIENC REGULATORY OR I  Continued From page  NJAC 8:39-19.4(a)  Sufficient Nursing Sta CFR(s): 483.35(a)(1)  §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and r resident safety and a practicable physical, well-being of each re- resident assessments and considering the r diagnoses of the facil accordance with the facil accordance with the facil accordance with the fact at §483.70(e).  §483.35(a)(1) The fact by sufficient numbers types of personnel or nursing care to all res- resident care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides  §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Complaint #: NJ0016 NJ00159215	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9  NJAC 8:39-19.4(a) Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)  §483.35(a) Sufficient Staff.  The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).  §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:  (i) Except when waived under paragraph (e) of this section, licensed nurses; and  (ii) Other nursing personnel, including but not limited to nurse aides.  §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.  This REQUIREMENT is not met as evidenced by:  Complaint #: NJ00160150, NJ00169450,	A BUILDING B. WING	A BUILDING  315185  31

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	0.0.00		ς.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	29/2023
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COMPLET	E CARE AT LINWOOD, I	LLC			01 NEW ROAD AND CENTRAL AVE INWOOD, NJ 08221		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 725	Continued From page	e 10	F7	725			
F 725	pertinent facility docu that the facility failed is staffing numbers to m requirements and b.) services to assure the or maintain the higher mental, and psychosoresident, as determine and individual plans of the facility assessment. This deficient practice residents (Resident #Ex.Order 26.4(b)(1) and following:  Refer F677(D)  a.) Reference: New J (NJDOH) memo, date with N.J.S.A. (New Jesus) 30:13-18, new minimum nursing homes," indice Governor signed into codified at N.J.S.A. 30 established minimum nursing homes. The feffective on 02/01/202	mentation it was determined to, a.) provide sufficient neet minimum staffing provide nursing and related to residents safety and attain st practicable physical, ocial wellbeing of each ed by resident assessments of care in accordance with nt.  The was identified for 2 of 3 and #14) observed for downs evidenced by the staffing requirements for the staffing requirements for staffing requirements in collowing ratio(s) were 21:  See Aide (CNA) to every eight	F	725	appropriate Ex.Order 26.4(b)(1) for residents who were Ex.Order 26.4(b)(1) Activities of Daily Living (ADLs) care. deficient practice was identified for 2 of residents reviewed for ADLs residents and #14.  Identify those individuals who could be affected by the deficient practice:  "All Residents have the potential to affected by this deficient practice.  "All were monitored for any adverse effects of the deficient practice with non noted.  What corrective action will be accomplished for those residents affect by the deficient practice:  "The facility continues to actively fill open CNA (Certified Nursing Assistant shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Hums Resource Director, who was able to reiterate minimum staffing requirement for nursing homes.  "The facility will take the following measures to ensure this deficient practices not occur. The facility 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 the content of the property with the current content of the positions with current content of the position of th	This f 3 f 3 #13 be ene ted I all ) an s ice	
	residents for the ever fewer than half of all s CNAs, and each direct	aff member to every 10 ning shift, provided that no staff members shall be ct staff member shall be a CNA and shall perform d			Administrator, Director of Nursing and Corporate Recruiter to advertise, recru and hire sufficient CNA staff; continue develop programs to attract Nursing Assistants including sign-on bonuses', shift bonuses, etc.; work with CNA class instructors to identify potential students	it to	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315185	B. WING			C <b>12/29/2023</b>	
NAME OF DE	ROVIDER OR SUPPLIER	0.0.00			STREET ADDRESS, CITY, STATE, ZIP CODE	121	29/2023
NAME OF P	ROVIDER OR SUPPLIER						
COMPLET	E CARE AT LINWOOD, I	_LC			01 NEW ROAD AND CENTRAL AVE		
	·			L	INWOOD, NJ 08221		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	Continued From page	÷ 11	F7	725			
	residents for the night	aff member to every 14 t shift, provided that each ber shall sign in to work as a A duties.			promote in-house programs to increase retention of current staff.  Measures or systemic changes to ensu		
	As ner the "Nurse Sta	affing Report" completed by			that the deficiencies will not recur:		
	the facility for the wee				" Administrator/designee to conduct		
	staffing-to-resident ra				compliance audits on effectiveness of		
	minimum requirements and is documented				hiring strategies to include open CNA a	ınd	
	below:				Licensed Nurse positions, reporting on		
					new hires, successful strategies-to-hire		
	For the week of Complaint staffing from 10/23/2022 to 10/29/2022, the facility was				and implementation of employee reten	ilon	
					programs.	:_4	
		ng for residents on 7 of 7 nt in total staff for residents			" The duration of all audits will cons of completion one-time weekly x 4 wee		
	on 7 of 7 overnight sh				then three-times monthly x2 months.	7.5	
	on r or r overnight si	into do followo.			Results of audits will be reviewed at the	Э	
	-10/23/22 had 12 CN/	As for 133 residents on the			Monthly Quality Assurance Meeting an	d	
	day shift, required at	least 17 CNAs.			Quarterly at facility QAPI Committee		
	-10/23/22 had 3 total	staff for 144 residents on			Meeting over the duration of the audit		
		quired at least 9 total staff.			process. Based on the results of these		
		As for 132 residents on the			audits, a decision will be made regardi		
	day shift, required at				the need for continued submission and		
		staff for 132 residents on			reporting.		
		quired at least 9 total staff.					
		As for 132 residents on the					
	day shift, required at						
		staff for 132 residents on quired at least 9 total staff.					
	•	As for 132 residents on the					
	day shift, required at						
		staff for 132 residents on					
		quired at least 9 total staff.					
	•	As for 132 residents on the					
	day shift, required at						
		staff for 132 residents on					
	•	quired at least 9 total staff.					
		As for 139 residents on the					
	day shift, required at	least 17 CNAs.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315185	B. WING		C 12/29/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  201 NEW ROAD AND CENTRAL AVE  LINWOOD, NJ 08221	12/29/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	BE COMPLETION	
F 725	the overnight shift, 1-10/29/22 had 9 CN day shift, required a -10/29/22 had 7 total the overnight shift, For the week of Con 12/11/2022 to 12/17 deficient in CNA staday shifts, deficient evening shifts, and residents on 7 of 7 a -12/11/22 had 14 C day shift, required a -12/11/22 had 3 total to overnight shift, required a -12/12/22 had 12 C day shift, required a -12/13/22 had 13 C day shift, required a -12/13/22 had 9 CN evening shift, required a -12/13/22 had 4 total the overnight shift, 1-12/13/22 had 12 C day shift, required a -12/14/22 had 13 C day shift, required a -12/15/22 had 13 C day shift, required a -12/15/22 had 13 C day shift, required a -12/15/22 had 13 C day shift, required a -12/16/22 had 13 C	al staff for 139 residents on required at least 10 total staff. IAs for 138 residents on the at least 17 CNAs. al staff for 138 residents on required at least 10 total staff.  Implaint staffing from 7/2022, the facility was affing for residents on 7 of 7 in CNAs to total staff on 1 of 7 deficient in total staff for overnight shifts as follows:  INAS for 130 residents on the at least 16 CNAs. al staff for 129 residents on the at least 16 CNAs. al staff for 129 residents on the at least 16 CNAs. al staff for 129 residents on the at least 16 CNAs. IAS for 129 residents on the at least 16 CNAs. IAS to 20 total staff on the red at least 10 CNAs. IAS to 20 total staff on the red at least 10 CNAs. IAS to 20 total staff on the red at least 10 CNAs. IAS to 20 total staff on the red at least 10 CNAs. IAS for 129 residents on the at least 16 CNAs. IAS for 129 residents	F 72			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		315185	B. WING			·	29/ <b>2023</b>
	ROVIDER OR SUPPLIER	L		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 01 NEW ROAD AND CENTRAL AVE INWOOD, NJ 08221	<u>  12//</u>	29/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	-12/17/22 had 13 CN. day shift, required at -12/17/22 had 3 total the overnight shift, re  For the 3 weeks of Co 12/03/2023 to 12/23/2 deficient in CNA staffi day shifts, deficient ir of 21 evening shifts, a residents on 21 of 21 -12/03/23 had 12 CN. day shift, required at -12/03/23 had 3 total the overnight shift, re -12/04/23 had 3 total the overnight shift, re -12/05/23 had 13 CN. day shift, required at -12/05/23 had 13 CN. day shift, required at -12/05/23 had 14 CN. day shift, required at -12/06/23 had 3 total the overnight shift, re -12/06/23 had 3 total the overnight shift, re -12/07/23 had 13 CN. day shift, required at -12/07/23 had 3 total the overnight shift, re -12/07/23 had 3 total the overnight shift, re -12/08/23 had 3 total the overni	quired at least 10 total staff. As for 137 residents on the least 17 CNAs. staff for 137 residents on quired at least 10 total staff.  Implaint staffing from 2023, the facility was ang for residents on 21 of 21 and deficient in total staff for overnight shifts as follows:  As for 138 residents on the least 17 CNAs. staff for 138 residents on quired at least 10 total staff. As for 138 residents on the least 17 CNAs. staff for 138 residents on quired at least 10 total staff. As for 138 residents on the least 17 CNAs. staff for 138 residents on quired at least 10 total staff. As for 138 residents on the least 17 CNAs. staff for 138 residents on quired at least 10 total staff. As for 138 residents on the least 17 CNAs. staff for 138 residents on the least 17 CNAs. staff for 138 residents on the least 18 CNAs. staff for 143 residents on the least 18 CNAs. staff for 143 residents on the least 18 CNAs. staff for 143 residents on the least 18 CNAs. staff for 143 residents on the least 18 CNAs. staff for 143 residents on the least 18 CNAs. staff for 143 residents on the least 18 CNAs. staff for 143 residents on the least 18 CNAs. staff for 143 residents on the least 18 CNAs.	F	725			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE (X7) MULTIPLE CONSTRUCTION (X7) MULTIPLE		(X3) DATE SURVEY COMPLETED		
	315185	B. WING		C 12/29/2023
NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT LINWOOD, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE  201 NEW ROAD AND CENTRAL AVE  LINWOOD, NJ 08221	12/20/2020
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE PREGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 725 Continued From page 14 -12/09/23 had 3 total staff for 14 the overnight shift, required at least 18 CI -12/10/23 had 3 total staff for 14 day shift, required at least 18 CI -12/11/23 had 3 total staff for 14 the overnight shift, required at least 18 CI -12/11/23 had 13 CNAs for 144 day shift, required at least 18 CI -12/11/23 had 4 total staff for 14 overnight shift, required at least -12/12/23 had 3 CNAs for 144 day shift, required at least 18 CI -12/12/23 had 3 total staff for 14 the overnight shift, required at le -12/13/23 had 3 total staff for 14 the overnight shift, required at le -12/13/23 had 3 total staff for 14 the overnight shift, required at le -12/14/23 had 14 CNAs for 143 day shift, required at least 18 CI -12/14/23 had 4 total staff for 14 the overnight shift, required at le -12/15/23 had 13 CNAs for 141 day shift, required at least 18 CI -12/15/23 had 3 total staff for 14 the overnight shift, required at le -12/16/23 had 3 total staff for 13 day shift, required at least 17 CI -12/16/23 had 3 total staff for 13 the overnight shift, required at le -12/17/23 had 13 CNAs for 135 day shift, required at least 17 CI -12/17/23 had 3 total staff for 13 the overnight shift, required at le -12/17/23 had 3 total staff for 13 the overnight shift, required at le -12/17/23 had 3 total staff for 13 the overnight shift, required at le -12/18/23 had 3 total staff for 13 the overnight shift, required at le -12/18/23 had 3 total staff for 13 the overnight shift, required at le -12/18/23 had 3 total staff for 13 the overnight shift, required at le -12/18/23 had 3 total staff for 13 the overnight shift, required at le -12/18/23 had 3 total staff for 13 the overnight shift, required at le -12/18/23 had 3 total staff for 13 the overnight shift, required at le -12/18/23 had 3 total staff for 13	east 10 total staff. residents on the NAs. 3 residents on east 10 total staff. residents on the NAs. 4 residents on the 10 total staff. residents on the NAs. 4 residents on the NAs. 5 residents on the NAs. 6 residents on the NAs. 7 residents on the NAs. 8 residents on the NAs. 8 residents on the NAs. 9 residents on the NAs. 9 residents on the NAs.	F 72	5	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315185	B. WING			C <b>12/29/2023</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	<u> </u>	12/29/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 725	day shift, required at 1-12/19/23 had 3 total the overnight shift, required at 1-12/20/23 had 12 CN/day shift, required at 1-12/20/23 had 3 total the overnight shift, required at 1-12/21/23 had 14 CN/day shift, required at 1-12/21/23 had 3 total the overnight shift, required at 1-12/22/23 had 11 CN/day shift, required at 1-12/22/23 had 3 total the overnight shift, required at 1-12/23/23 had 14 CN/day shift, required at 1-12/23/23 had 10 CN/evening shift, required -12/23/23 had 3 total the overnight shift, required -12/23/23 had 10 CN/day shift, required -12/23/23 had 3 total the overnight shift, required -12/23/23 had	east 17 CNAs. staff for 135 residents on quired at least 10 total staff. As for 135 residents on the east 17 CNAs. staff for 135 residents on quired at least 10 total staff. As for 141 residents on the east 18 CNAs. staff for 141 residents on quired at least 10 total staff. As for 139 residents on the east 17 CNAs. staff for 139 residents on quired at least 10 total staff. As for 139 residents on quired at least 10 total staff. As for 135 residents on the east 17 CNAs. As to 23 total staff on the dat least 11 CNAs. staff for 135 residents on quired at least 10 total staff. AM, the surveyor interviewed NAs are usually assigned to cause of being "short staffed er stated they will have griment "if lucky."  the surveyor interviewed Unit Manager (RN/UM #1), ing could be a potential order 26.4(b)(1) being  tM, the surveyor interviewed g (DON) regarding staffing. The required staffing ratio	F 7.	25			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		315185	B. WING		C <b>12/29/2023</b>	
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  201 NEW ROAD AND CENTRAL AVE  LINWOOD, NJ 08221	12/25/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 725	On 12/29/23 at 9:52 the staffing coordina staffing ratios for the residents per CNA, residents per CNA, residents per CNA, residents per CNA, these ratio requirem outs but stated "we call outs)." She furth runs on 12-hour nur  b.) On 12/29/23 at 7 accompanied by Ce (CNA) completed at South Wing Nursing residents who were being dependent or for Ex.Order 26.4(b)(1 and CNA #3 entered Resident #13 was in gown. Resident #13 odors were discove granted permission their Ex.Order 26.4(b)  Ex.Order 26.4(b)  CNA opened that underneath. The this time the CNA in residents should no the reason the reside put on was due to b  On 12/29/23 at 8:05 #2 in the presence of #14 in bed. Resider no odor was discove granted permission Ex.Order 26.4(b)(1)	AM, the surveyor interviewed ator. She stated the CNA at 7 AM to 3 PM shift was 8 for the 3 PM to 11 PM shift 10 for the 11 PM to 7 AM shift 14 She stated the facility meets sents when there are no call have a lot of those (meaning her stated since the facility sing shifts, "it's tricky."  2:52 AM, the surveyor rtified Nursing Assistants in incontinence tour on the Unit. Three random identified by the CNAs as staff for care, were observed as Surveyor #1, Surveyor #2 Resident #13's room. In bed wearing a hospital style is sheets were dry, and no red. At that time, the resident for the surveyors to observe (1). Surveyor #1 observed an (1) to the resident. The exposing an additional ne addition [EX.Order 26.4(b)(1)]. At formed the surveyors that the EX.Order 26.4(b)(1) He stated	F 72			

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		315185	B. WING _			C <b>12/29/2023</b>
	ROVIDER OR SUPPLIER  E CARE AT LINWOOD,	LLC		STREET ADDRESS, CITY, STATE, ZIP C 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	ODE	12/23/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 725	opened the worker expunderneath. The Exthat time, CNA #4 stanever be so The resident the liped to the toilet so commode.  Review of the facility titled "Nursing Service but was not limited to sufficient nursing standard related services attain or maintain the mental, and psychos resident, as determinand individual plans number, acuity and cresident population in assessment provide limited to assessing, implementing resident to resident needs"  Review of the facility (ADLs)" policy (Updatollowing:  "Appropriate care and for residents who are independently, with the and in accordance we appropriate support as a. hygiene (bathing, care);	Order 26.4(b)(1) . At ated that residents should fed with two hen asked the CNA to be to that they could use the a straight of the could use the could use the a straight of the could use the	F7	725		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED C		
		315185	B. WING _			12/29/2023
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 725	Continued From page	e 18	F 7	25		
	e. communication (sp functional communication	peech, language, and any ation systems)."				
F 919 SS=D	NJAC 8:39-5.1(a), 27 Resident Call System CFR(s): 483.90(g)(1)	1	F 9	19		1/26/24
	residents to call for so	Call System Idequately equipped to allow Itaff assistance through a Im which relays the call Inber or to a centralized staff				
	§483.90(g)(2) Toilet a	「 is not met as evidenced		Residents affected by deficient	practice:	
	NJ00160202  Based on observation pertinent facility docudetermined that the facility documents are supported by the support of	n, interview, and review of imentation, it was acility failed to maintain the stem to operate as designed		The facility failed to maintain the call system to operate as design deficient practice was identified to call bells observed. Star Spa Bar Room 63, and Visitor ☐s Bathroomain lobby.	nurse led. This for 3 of 5 throom,	
	following: On 12/29/23 at 8:00 A North Wing Unit, no r light illuminated abov	AM, the surveyor observed resident rooms had a call bell re room doors.		Identify those individuals who confected by the deficient practice  " All residents have the potent affected by the deficient practice  " All residents were monitored adverse effects of the deficient provident with none noted.	e: Itial to be e. d for any	
	"Star Spa Bathroom" Wing and observed t	(shower room) on North hree call systems. The call he toilet was activated by the		What corrective action will be accomplished for those residents by the deficient practice:	s affected	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		315185	B. WING			C 2/29/2023	
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221		2/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO	ULD BE	(X5) COMPLETION DATE	
F 919	Continued From page surveyor at 8:12 am. minutes and exited the notice no light was ill.  On 12/29/23 at 8:15 the Unit Clerk (UC). System is activated the station will sound and triggered in, additions will illuminate. She also a resident room, it willight and the bathroof flashing light. The surlight outside the door no ringing of the call station.  On 12/29/23 at 8:23 the call bell system of the entrance of the faction of the bathroom above the door. The East Wing call bell losurveyor observed the but it did not indicate.  On 12/29/23 at 8:32 the Unit Manager Lice (UM/LPN). The surveto pick a random unit call system. The UM/LPN to the tental call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system. The UM/LPN to pick a random unit call system.		F 9 <sup>2</sup>	DEFICIENCY)	as, and l. ras wer it tool. ducated g ing that I staff ely to our ce ensure signee the consist weeks at the ng and ee udit these		
	observed a white call entrance door of room alarm was activated surveyor and UM/LP station where the Ma present. The UM/LPN	l light illuminate above the m 63, indicating the call bell in that room. At this time, the N proceeded to the nurses intenance Director was N and the Maintenance e call bell indicator at the		the need for continued submission reporting.			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		315185	B. WING		C 12/29/2023	
	ROVIDER OR SUPPLIER	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  201 NEW ROAD AND CENTRAL AVE  LINWOOD, NJ 08221	12/23/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 919	had been activated.  On 12/29/23 at 8:42 a surveyor interviewed Director. He confirmed alarming but could not alarm. At this time, the Certified Nurses Assi #2, both CNAs confir triggered, and they "could not identify the this time, the Mainter by the surveyor proceduring hall and turned system off.  On 12/29/23 at 8:53 at the Maintenance Director Spa Bathroom, where activated at 8:12 AM confirmed that the callight was illuminated at the nurses station. confirmed that the callight was incompleted was 10/31 that all the call bell systems of the survey team, the survey team and stated the last time completed was 10/31 that all the call bell systems of the confirmed that the survey team, the survey team and stated the last time completed was 10/31 that all the call bell systems of the confirmed that the call bell systems of the confirmed that the survey team and stated the last time completed was 10/31 that all the call bell systems or the confirmed that the call bell systems of the confirmed that the call bell systems or the confirmed that the call the call the confirmed that	AM, on the East Wing, the the facility Maintenance and the call bell system was bet identify the location of the resurveyor also interviewed stants #1 (CNA #1) and CNA med that the call system was checked every room" but location of the call alarm. At nance Director accompanied reded to the visitor's netrance of the facility by the distribution that the call was initially and the call bell was initially. The Maintenance Director all light next to the toilet is wor and the Maintenance atthroom, and no flashing red above the door or alarming. The Maintenance Director II systems were not working working."	F 91	9		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTI			(X3) DATE SURVEY COMPLETED		
		315185	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 NEW ROAD AND CENTRAL AVE LINWOOD, NJ 08221	·	12/29/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 919	lights last updated on not limited to, "check to ensure that cord le light is in working ord lights promptly to mai repair and arranges for change patients room resident."  Review of the facility "check call bells in face	r provided policy on call 1/2022 included but was lights when providing care ngth is appropriate, and that er. Report defective call ntenance for immediate or alternate call system or and frequent checks on call bell checklist included, cility once per quarter. r lights, and nurses stations beds."	F 9	19		

New Jersey Department of Health

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		060104	B. WING		12/2	; 9/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMPLET	TE CARE AT LINWOOD,	LLC 201 NEW R LINWOOD,	OAD AND CE NJ 08221	NTRAL AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments		S 000			
	NJ159215, NJ160024  The facility was not in standards in the New	202, NJ159616, NJ165150, 4, NJ160394, NJ169450 In compliance with all of the by Jersey Administrative Code, ands for Licensure of Long				
	Term Care Facilities. plan of correction, inceach deficiency and cimplemented. Failure result in enforcement the provisions of the	The facility must submit a cluding a completion date, for ensure that the plan is to correct deficiencies may action in accordance with New Jersey Administrative of 43E, Enforcement of				
S 560	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.		S 560			1/26/24
	by:	is not met as evidenced		Residents affected by deficient practic	ce:	
	pertinent facility docu determined the facilit required minimum dir	n, interview, and review of amentation, it was y failed to maintain the rect care staff-to-resident y the state of New Jersey.		The facility failed to ensure staffing rativere met to maintain the required minimum staff-to-resident ratio as mandated by the State of New Jersey Identify those individuals who could be affected by the deficient practice:	'.	
	(NJDOH) memo, date with N.J.S.A. (New Je	ey Department of Health ed 01/28/2021, "Compliance ersey Statutes Annotated) um staffing requirements for		" All residents have the potential to affected by this deficient practice.  " All residents monitored for any adverse effects of the deficient practic with none noted.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

01/12/24

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		060104	B. WING		C <b>12/29/2023</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
COMPLET	E CARE AT LINWOOD, I	LLC 201 NEW R LINWOOD,	OAD AND CE NJ 08221	NTRAL AVE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
S 560	Continued From page	<del>:</del> 1	S 560			
	established minimum nursing homes. The freffective on 02/01/2020. One (1) Certified Nursi (8) residents for the domain of the every fewer than half of all second one (1) direct care stresidents for the every fewer than half of all second one (1) direct care stresidents for the night	law P.L. 2020 c 112, 0:13-18 (the Act), which staffing requirements in ollowing ratio(s) were 21: se Aide (CNA) to every eight ay shift. aff member to every 10 hing shift, provided that no staff members shall be at CNA and shall perform d aff member to every 14 at shift, provided that each ber shall sign in to work as a		What corrective action will be accomplished for those residents affect by the deficient practice:  "The facility continues to actively for open CNA (Certified Nursing Assistant shifts to comply with New Jersey State mandated ratios. Minimum staffing requirements were reviewed with Hum Resource Director, who was able to reiterate minimum staffing requirement for nursing homes.  "The facility will take the following measures to ensure this deficient practices not occur. The facility will focus recruitment and retention strategies as following: identify vacant positions dai and attempt to fill positions with currer CNA staff or agency; work diligently well administrator, Director of Nursing and Corporate Recruiter to advertise, recruiter to advertise.	ill all t) e nan ts ctice s ty nt ith	
	following:	tio did not meet the ts and is documented plaint staffing from		and hire sufficient CNA staff; continue develop programs to attract Nursing Assistants including sign-on bonuses' shift bonuses, etc.; work with CNA cla instructors to identify potential student promote in-house programs to increas retention of current staff.  Measures or systemic changes to enst that the deficiencies will not recur:  "Administrator/designee to audit the	ss s; se ure	
	deficient in CNA staffi day shifts and deficient on 7 of 7 overnight shifts -10/23/22 had 12 CNA day shift, required at 1	ng for residents on 7 of 7 nt in total staff for residents iifts as follows:  As for 133 residents on the		effectiveness of hiring strategies to incopen CNA and Licensed Nurse positions. In the strategies to hir open CNA and Licensed Nurse positions. In the strategies to hire based on percentage and turnover rates.  The duration of all audits will consoft completion one-time weekly x 4 week	clude ons es, sist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060104	B. WING		C <b>12/29/2023</b>
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE	
COMPLETE CARE AT LINWOOD, I	LLC	ROAD AND CE , NJ 08221	NTRAL AVE	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
-10/24/22 had 13 CN. day shift, required at -10/24/22 had 3 total the overnight shift, re -10/25/22 had 14 CN. day shift, required at -10/25/22 had 3 total the overnight shift, re -10/26/22 had 13 CN. day shift, required at -10/26/22 had 3 total the overnight shift, re -10/27/22 had 12 CN. day shift, required at -10/27/22 had 3 total the overnight shift, re -10/27/22 had 3 total the overnight shift, re -10/28/22 had 3 total the overnight shift, re -10/28/22 had 3 total the overnight shift, re -10/29/22 had 9 CNA day shift, required at -10/29/22 had 7 total the overnight shift, re For the week of Com 12/11/2022 to 12/17/2 deficient in CNA staffi day shifts, deficient in evening shifts, and deresidents on 7 of 7 ov -12/11/22 had 14 CN. day shift, required at -12/11/22 had 3 total overnight shift, required at -12/11/22 had 3 total overnight shift, required at -12/12/22 had 12 CN. day shift, required at -12/12/22 had 12 CN.	quired at least 9 total staff. As for 132 residents on the least 16 CNAs. staff for 132 residents on quired at least 9 total staff. As for 132 residents on the least 16 CNAs. staff for 132 residents on quired at least 9 total staff. As for 132 residents on the least 16 CNAs. staff for 132 residents on the least 16 CNAs. staff for 132 residents on quired at least 9 total staff. As for 132 residents on the least 16 CNAs. staff for 132 residents on quired at least 9 total staff. As for 139 residents on the least 17 CNAs. staff for 139 residents on quired at least 10 total staff. s for 138 residents on the least 17 CNAs. staff for 138 residents on quired at least 10 total staff. plaint staffing from 2022, the facility was ing for residents on 7 of 7 or CNAs to total staff or 7 or CNAs to total staff for 7 or CNAs to total staff for 7 or CNAs to total staff for 7 or CNAs to total staff on 1 of 7 or 10 CNAs to total staff on 1 of 7 or 10 CNAs to total staff on 1 of 7 or 10 CNAs to total staff on 1 of 7 or 10 CNAs to total staff on 1 of 7 or 10 CNAs to total staff on 1 of 7 or 10 CNAs to total staff on 1 of 7 or 10 CNAs to total staff on 1 of 7 or 10 CNAs to total staff on 1 of 10 or 10 o	S 560	then three times monthly x 2 months. Results of audits will be reviewed at the Monthly Quality Assurance Meeting a Quarterly at facility QAPI Committee Meeting over the duration of the audit process. Based on the results of the audits, a decision will be made regard the need for continued submission an reporting.	ne nd se ling

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRI	ECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED	
		060104	B. WING		C <b>12/29/2023</b>	
NAME OF PROVIDER	OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
COMPLETE CARE	E AT LINWOOD, I	LC	ROAD AND CE , NJ 08221	NTRAL AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	E E
the ov -12/13 day sh -12/13 evenir -12/14 day sh -12/14 the ov -12/15 day sh -12/16 day sh -12/16 day sh -12/17 day sh -12/17 the ov -12/17 day sh -12/17 day sh -12/10 day sh -12/10 day sh of 21 or reside -12/03 day sh -12/04 day sh -12/03 day sh -12/03	s/22 had 13 CNA hift, required at 1 3/22 had 9 CNA ng shift, required s/22 had 4 total ernight shift, re- s/22 had 12 CNA hift, required at 1 4/22 had 4 total ernight shift, re- s/22 had 13 CNA hift, required at 1 5/22 had 3 total ernight shift, re- s/22 had 3 total ernight shift, re- s/23 had 3 total ernight shift, re- s/23 had 12 CNA hift, required at 1 5/23 had 3 total ernight shift, re- s/23 had 3 total ernight shift, re-	quired at least 9 total staff. As for 129 residents on the least 16 CNAs. Is to 20 total staff on the dat least 10 CNAs. Istaff for 129 residents on quired at least 9 total staff. As for 129 residents on the least 16 CNAs. Istaff for 129 residents on quired at least 9 total staff. As for 129 residents on the least 16 CNAs. Istaff for 129 residents on the least 16 CNAs. Istaff for 129 residents on the least 17 CNAs. Istaff for 137 residents on the least 17 CNAs. Istaff for 137 residents on the least 17 CNAs. Istaff for 137 residents on the least 17 CNAs. Istaff for 137 residents on the least 17 CNAs. Istaff for 137 residents on the least 17 CNAs. Istaff for 137 residents on the least 17 CNAs. Istaff for 137 residents on the least 17 CNAs. Istaff for 138 residents on 1 and deficient in total staff for overnight shifts as follows:  As for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs. Istaff for 138 residents on the least 17 CNAs.	S 560			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		160
					c	;
		060104	B. WING		12/2	9/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
COMPLET	E CARE AT LINWOOD	201 NEW F	OAD AND CE	NTRAL AVE		
COMPLE	TE CARE AT LINWOOD, I	LINWOOD,	NJ 08221			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	DATE
S 560	Continued From page	e 4	S 560			
	day shift, required at	least 17 CNAs.				
		staff for 138 residents on				
	the overnight shift, re	quired at least 10 total staff.				
		As for 138 residents on the				
	day shift, required at	least 17 CNAs.				
	-12/06/23 had 3 total	staff for 138 residents on				
	the overnight shift, re	quired at least 10 total staff.				
		As for 143 residents on the				
	day shift, required at					
		staff for 143 residents on				
		quired at least 10 total staff.				
		As for 143 residents on the				
	day shift, required at					
		staff for 143 residents on				
		quired at least 10 total staff.				
		As for 143 residents on the				
	day shift, required at	staff for 143 residents on				
		quired at least 10 total staff.				
		As for 143 residents on the				
	day shift, required at					
		staff for 143 residents on				
		quired at least 10 total staff.				
		As for 144 residents on the				
	day shift, required at	least 18 CNAs.				
	-12/11/23 had 4 total	staff for 144 residents on the				
	overnight shift, require	ed at least 10 total staff.				
	-12/12/23 had 13 CN	As for 144 residents on the				
	day shift, required at					
	,,	staff for 144 residents on				
		quired at least 10 total staff.				
		As for 143 residents on the				
	day shift, required at					
		staff for 143 residents on				
	_	quired at least 10 total staff.				
		As for 143 residents on the				
	day shift, required at					
		staff for 143 residents on				
	_	quired at least 10 total staff.				
	- 12/ 13/23 Nag 13 CN/	As for 141 residents on the	1			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
						С
		060104	B. WING			/29/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
COMPLET	FE CARE AT LINWOOD I	201 NEW	ROAD AND CENT	RAL AVE		
COMPLE	TE CARE AT LINWOOD, I	LINWOOI	D, NJ 08221			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
S 560	day shift, required at I-12/15/23 had 3 total the overnight shift, required at I-12/16/23 had 13 CN/day shift, required at I-12/16/23 had 3 total the overnight shift, required at I-12/17/23 had 3 total the overnight shift, required at I-12/18/23 had 9 CNA/day shift, required at I-12/18/23 had 3 total the overnight shift, required at I-12/18/23 had 3 total the overnight shift, required at I-12/19/23 had 3 total the overnight shift, required at I-12/19/23 had 3 total the overnight shift, required at I-12/19/23 had 3 total the overnight shift, required at I-12/19/23 had 3 total the overnight shift, required at I-12/19/23 had 3 total the overnight shift, required shift, required at I-12/19/23 had 3 total the overnight shift, required shift, shift, required shift, required shift, required shi	east 18 CNAs. staff for 141 residents on quired at least 10 total staff. As for 139 residents on the east 17 CNAs. staff for 139 residents on quired at least 10 total staff. As for 135 residents on the east 17 CNAs. staff for 135 residents on quired at least 10 total staff. s for 135 residents on the east 17 CNAs. staff for 135 residents on the east 17 CNAs. staff for 135 residents on the quired at least 10 total staff. As for 135 residents on quired at least 10 total staff. As for 135 residents on the	S 560			
	the overnight shift, rec-12/21/23 had 14 CN/day shift, required at I-12/21/23 had 3 total the overnight shift, rec-12/22/23 had 11 CN/day shift, required at I-12/22/23 had 3 total the overnight shift, rec-12/23/23 had 14 CN/day shift, required at I-12/23/23 had 10 CN/evening shift, required -12/23/23 had 3 total the overnight shift, rec-12/23/23 had 3 total the overnight shift, rec-12/23/23 at 7:39 A	staff for 135 residents on equired at least 10 total staff. As for 141 residents on the east 18 CNAs. staff for 141 residents on equired at least 10 total staff. As for 139 residents on the east 17 CNAs. staff for 139 residents on equired at least 10 total staff. As for 135 residents on the east 17 CNAs. As for 135 residents on the east 17 CNAs. As to 23 total staff on the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
			D WING		С
		060104	B. WING		12/29/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
COMPLET	E CARE AT LINIMOOD	201 NEW	ROAD AND CE	NTRAL AVE	
COMPLET	E CARE AT LINWOOD, I	LINWOO	D, NJ 08221		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	
S 560	Continued From page	e 6	S 560		
	11 to 14 residents bed	cause of being "short staffed			
		er stated they will have			
	"only" 9 resident assig	_			
		•			
		the surveyor interviewed			
		Unit Manager (RN/UM #1),			
		ing could be a potential			
	cause of resident Ex.C affected.	being			
	anected.				
	On 12/29/23 at 8:40 A	AM, the surveyor interviewed			
		g (DON) regarding staffing.			
		he required staffing ratio			
	and stated she believ	· -			
		AM, the surveyor interviewed			
	_	or. She stated the CNA			
	•	7 AM to 3 PM shift was 8 or the 3 PM to 11 PM shift 10			
		or the 11 PM to 7 AM shift 14			
		he stated the facility meets			
	·	nts when there are no call			
		ave a lot of those (meaning			
		r stated since the facility			
	runs on 12-hour nursi	ng shifts, "it's tricky."			
	D : (11 ( 111)				
	_	s provided staffing policy			
		es" dated 2/1/2022 included , "the facility will have			
	sufficient nursing staf	_			
	_	ills sets to provide nursing			
		o assure resident safety and			
		highest practicable physical,			
		ocial well-being of each			
	resident, as determine	ed by resident assessments			
	-	of care and considering the			
	_	iagnoses of the facility's			
		accordance with the facility			
		ing care includes but is not			
	limited to assessing, e	evaluating, planning and			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				_		С
		060104	B. WING		12	/29/2023
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
COMPLET	E CARE AT LINWOOD, I	_LC	ROAD AND CE D, NJ 08221	NTRAL AVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
S 560	1 3	t care plans and responding	S 560			
ı						

	POST	-CERTIFIC	ATION REVISIT RE	PORT			
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONS	TRUCTION			DATE OF REVISIT		
IDENTIFICATION NUMBER	A. Building				2/7/2024		
315185	Y1 B. Wing				Y2 2/7/2024		
NAME OF FACILITY	FACILITY STREET ADDRESS, CITY, STATE, ZIP CODE						
COMPLETE CARE AT LINWOO	COMPLETE CARE AT LINWOOD, LLC 201 NEW ROAD AND CENTRAL AVE						
			LINWOOD, NJ 08221				
program, to show those deficient corrected and the date such co	ncies previously repo rrective action was a	orted on the CMS-25 accomplished. Each	Medicaid and/or Clinical Laborator 67, Statement of Deficiencies and deficiency should be fully identifie the CMS-2567 (prefix codes show	Plan of Correction, the dusing either the regu	at have been ulation or LSC		
ITEM	DATE	ITEM	DATE	ITEM	DATE		
Y4	Y5	Y4	Y5	Y4	Y5		

			STATE FOR	RM: REVISIT REPORT		
	OVIDER / SUPPLIER / CLIA / NTIFICATION NUMBER 0104  MULTIPLE CONSTRUCTION A. Building B. Wing					
	FACILITY TE CARE AT LINW			STREET ADDRESS, CIT 201 NEW ROAD AND CI LINWOOD, NJ 08221	Y2 21112024	
corrective	e action was accomption prefix code prev	plished. Each deficien	cy should be fully ider	oreviously reported that have been ntified using either the regulation refix codes shown to the left of e	or LSC provision num	ber and the
ITE	M	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
D Prefix	S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	8:39-5.1(a)	Completed	Reg. #	Completed	Reg.#	Completed
LSC		01/26/2024	LSC		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

Completed

Reg. #

LSC

Completed

Reg. #

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