STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055**

(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
F0000	INITIAL COMMENTS Complaints: 401472, 401473,2597374 Survey Date: 9/9/25 Census 107 Sample: 22 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		11/03/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 1 of 22 residents reviewed for accommodation of needs (Resident #96), and was evidenced by the following: On 09/04/25 at 8:07 AM, the surveyor observed Resident #96 in bed. The surveyor observed the Resident's call light pull cord (used to summon staff for assistance) affixed to the upper aspect of the right-side rail, not within his/her reach. The resident stated, "There should be a string around here somewhere, but I can't seem to find it, so I can't call for help." The surveyor reviewed the medical record for Resident #96. A review of the Admission Record reflected the Resident was admitted to the facility with diagnoses that included but were not limited to; [redacted]	F0558	Resident #96 was affected by the deficient practice. The assigned [redacted] was counselled and re-educated on the facility's policy on "Call lights. All residents have the potential to be affected by this deficient practice. All rooms were checked to make sure that all call light pull cords were conveniently positioned for use and within the reach of the resident. In-service on the facility's policy on call lights was initiated by the DON/Designee for all nursing staff. The DON/Designee will audit 10 rooms weekly to ensure all call light pullcords are within resident reach. Audits will be conducted weekly x4 weeks then monthly x2 months to ensure compliance with the call light policy. Results of this audit will be reviewed and discussed during the monthly Quality Performance Improvement (QAPI) meeting.	11/03/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0558 SS = D	Continued from page 1 NJ Exec Order 26.4b1 [redacted]. A review of Resident #96's Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed Resident #96 had a Brief Interview for Mental Status score of NJ Exec Order 26.4b1 which indicated the resident's NJ Exec Order 26.4b1. The MDS further revealed that the resident required [redacted] from staff for activities of daily living care. A review of Resident #96's Individualized Care Plan (CP) initiated on [redacted] had a focus that indicated the resident was at NJ Exec Order 26.4b1 with interventions that included but were not limited to: ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 9/4/25 at 8:18 AM, the surveyor showed the U.S. FOIA (b)(6) [redacted] assigned to Resident #96's care the call light pull cord affixed to the upper aspect of the NJ Exec Order 26.4b1, not within the resident's reach. The U.S. FOIA confirmed that she should have placed the pull cord within the resident's reach. On 9/8/25 at 12:28 PM, the survey team met with the U.S. FOIA (b)(6) [redacted] to discuss the above observations and concerns. A review of the facility's policy, "Call Lights," dated 1/25, revealed:Always position the call light conveniently for use and within the reach of the resident. NJAC 8:39-27.1 (a); 31.8 (c) (9)	F0558		
F0584 SS = D	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	F0584	The U.S. FOIA (b)(6) [redacted]) was notified about the findings in rooms NJ Exec Order 26.4b1 He reported that replacements for the broken drawers and broken panels for the headboards in rooms NJ Exec Order 26.4b1 were ordered and awaiting delivery. Peeling paint and exposed sheet rock on both rooms were fixed immediately. The portable oxygen tank found in room NJ Exec Ord was removed immediately. The U.S. FOIA was notified about the swarm of flying insects and documented in the pest control book. U.S. FOIA (b)(6) [redacted]) (in NJ Exec Order 26.4b) was notified about the heavily soiled bathroom floor, the heavily soiled toilet, the toilet seat, bathroom floor, and the toilet paper dispenser The U.S. FOIA cleaned all mentioned immediately. The overflowing garbage can in room NJ Exec was removed by the U.S. FOIA immediately. The plastic bag with dirty linen in room NJ Exec was removed by the U.S. FOIA and placed in the designated container. The plastic bags containing resident's NJ Exec Ord were sorted out by U.S. FOIA and were returned to the residents immediately. All residents have the potential to be affected by these deficient practices.	11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0584 SS = D	Continued from page 2 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 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: Complaint #NJ 401472 Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to a.) maintain a homelike environment that was clean, safe, and sanitary in 3 out of 24 resident rooms (rooms NJ Exec Order 26.4b1) and b.) ensure that personal clothing items, specifically NJ Exec Or, were returned after being laundered to 5 out of 5 residents who attended the resident council meeting (Resident #25, 67, 70, 83, 85). Additionally, Resident # 96 complained that their NJ Exec Or were not returned after being laundered. This deficient practice was evidenced by the following: 1. On 9/2/2025 at 11:06 AM, the surveyor observed in room NJ Exec a broken dresser drawer, peeling paint with exposed plaster and sheet rock to the right of the sink. On 9/2/25 at 12:00 PM, the surveyor observed in room NJ Exec Or a portable oxygen tank heavily soiled with rust and a brown substance, with a swarm of flying	F0584	Continued from page 2 The broken drawers in rooms NJ Exec Order 26.4b1 were replaced on 09/18/2025. New panels needed for area behind the headboards repair were ordered and awaiting delivery. Floor tiles were ordered to replace the stained floor tiles in rooms NJ Exec Order 26.4b1. All rooms were checked for soiled linens and trash collection and portable oxygen tank with no active order. The U.S. FOIA (b)(6) initiated an in-service on facility policy for Laundry Delivery and facility policy on cleaning/disinfecting of rooms. The U.S. FOIA (b)(6) in-serviced the U.S. FOIA (b and assistant on facility policy on Resident Environmental Quality and Pest control programs. The DON/Designee initiated an in-service on facility policy on Soiled Linen and trash Containers for all nursing staff and housekeeping staff. The U.S. FOI will conduct 10 audits weekly on compliance with facility policy on Laundry Delivery and facility policy on cleaning and disinfecting of rooms. Audits will be completed weekly x4 and monthly x3 months. The results of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0584 SS = D	Continued from page 3 insects around the oxygen tank. The surveyor observed the wall by the headboard was cracked with exposed sheet rock and was heavily soiled with a brown substance. The armoire was observed to have had broken drawers and large cracks with missing pieces. On 9/4/25 at 8:07 AM, the surveyor observed that the bathroom floor in room [redacted] was heavily soiled with a brown substance around the base of the toilet. Additionally, the toilet was soiled with a yellow substance, and the toilet paper dispenser was heavily rusted. The metal panels on the bottom of the door, both inside and outside, were also heavily soiled with a brown material. On 9/4/25 at 8:43 AM, the surveyor and the [redacted]) entered room [redacted] and observed an unpleasant, offensive smell in the bathroom. They noted the floor was soiled with a yellow material, and a large plastic bag was on the floor full of soiled linens, with insects swarming the bag. The [redacted] and the surveyor also observed that the garbage can was overflowing with trash, which was also scattered on the floor. The surveyor and [redacted] further observed that in room [redacted] the floor was soiled with food and liquids, and the bedside table had a sticky yellow substance on it with flying insects swarming the area. On 9/4/25 at 8:45 AM, during an interview with the surveyor, the maintenance staff member acknowledged the broken armoire in room [redacted] and the disrepair of the wall behind the bed. The maintenance staff member stated that the facility was aware of the broken dresser and had ordered a new one "about 2 months ago" and had also ordered new panels for the areas behind the headboards. On 9/4/25 at 8:50 AM, during an interview with the surveyor, the [redacted] stated that the facility staff were responsible for listing repairs that needed to be done in the book that was kept at the nurses' station. At that time, the surveyor and [redacted] reviewed the book and observed that no repairs had been documented for rooms [redacted], but confirmed that the concerns in all three rooms should have been addressed. On that same date, at that same time, the [redacted] confirmed that rooms [redacted] needed cleaning and that the rooms and bathrooms failed to meet the clean, comfortable, homelike environment standards. 2.) On 9/4/25 at 8:07 AM, during an interview with the surveyor, Resident #96 stated that they were missing all of their [redacted] The resident further stated that he/she had mentioned it to the housekeeping staff and nursing staff many times, but they still had not returned the [redacted] On 9/4/25 at 10:30 AM, the surveyor conducted the Resident Council meeting with 5 residents whom the facility chose to attend. All 5 residents stated that they were missing [redacted]. They further stated that they had informed the housekeeping staff and the nursing staff but still had	F0584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0584 SS = D	Continued from page 4 not received their [NJ Exec Ord] back. The 5 residents stated it had been over a month since their [NJ Exec Or] went missing. On 9/8/25 at 8:10 AM, during an interview with the surveyor, in the presence of the U.S. FOIA (b)(6) [redacted]), the U.S. FOIA (b)(6) [redacted] responsible for laundry stated that several residents had complained to her that their [NJ Exec Ord] were not returned after being laundered. The housekeeping staff stated that she was very busy and had not had time to pair or deliver the residents' [NJ Exec Ord] in over a month. At that time, the [U.S. FOIA] also confirmed that the residents had complained to her several times about their missing [NJ Exec Or]. The surveyor toured the laundry room and observed five large plastic bags full of residents' persona[NJ Exec Orde] which the U.S. FOIA (b)(6) [redacted] member acknowledged was unacceptable. On 9/8/25 at 10:05 AM, the surveyor discussed the above observations and concerns with the U.S. FOIA (b)(6) [redacted] stated that she had observed the five large bags of residents' [NJ Exec Or] in the laundry room and that it was unacceptable. A review of the facility's policy, "Laundry Delivery", reflected...Laundry is done and returned within 24-72 hours... A review of the facility's policy, "Handling Clean Linen", dated 9/1/24, reflected...It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary manner... A review of the facility's policy, "Safe and Homelike Environment," dated 10/1/24, reflected...In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing residents to use their personal belongings... A review of the facility's policy, "Environmental Services Inspection," reflected...It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. NJAC 8:39 31.4 (a)	F0584		
F0692 SS = D	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 comprehensive assessment, the facility must ensure that a resident-	F0692	Resident #2 was affected by this deficient practice. [NJ Exec Order 26.4b1] was done for the [NJ Exec]-floor unit manager that included review of the facility [NJ Exec Order 26.4b1] Policy and that a physician's order for a specific weight schedule should be followed accurately. All residents have the potential to be affected by this deficient practice. A medical record audit was conducted to determine compliance to the facility's [NJ Exec Order 26.4b1] Policy. Monthly [NJ Exec Ord] order on the Physician order sheet (POS) was updated to ensure that [NJ Exec Order 2]are taken and	11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0692 SS = D	Continued from page 5 §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, interview and review of pertinent facility documentation, it was determined that the facility failed to monitor the NJ Exec Order 26.4 status for 1 of 2 residents reviewed (Resident #2), specifically by not following a physician's orders for monitoring of Resident #2's NJ Ex Order 26. The deficient practice was evidenced by the following: On 9/3/25 at 11:29 AM, the surveyor observed Resident #2 in bed with the NJ Exec Order 26.4b1, NJ Exec Order 26.4b1 and not NJ Exec Orde A review of Resident #2's Admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 A review of Resident #2's annual Minimum Data Set (MDS), an assessment tool, reflected that the resident was NJ Exec Order 26.4b1 . A review of the resident's Physician Order Summary report reflected the following physician's orders (POs): 1. obtain the resident's NJ Exec Orde one time a week on NJ Exec Order 26.4b1 initiated on NJ Exec Order 26 2. PO dated NJ Exec Order 26.4 to NJ Exec Orde resident on day shift every month on the 1st day of the month and 3. a PO dated NJ Exec Order 26.4b1 resident on the day shift every month on the 1st day of the month.	F0692	Continued from page 5 recorded on resident's medical record following specific weight schedule ordered by the physician. A weight book log will be maintained on the unit to ensure that all weights are done and recorded on resident's medical record following specific weight schedule. All nursing staff were re-educated on the facility's NJ Exec Order 26.4b1 Policy by the registered Dietician/Designee. The Director of Nursing/designee will conduct 10 audits on the resident's medical record to ensure that specific weight schedules are followed and documented following the facility's weight monitoring policy. Audits will be done weekly x 4 weeks and monthly x1 month. The results of the audits will be reviewed at the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0692 SS = D	Continued from page 6 A review of Resident #2's medical record did not indicate that a [NJ Exec Orde] was obtained on [NJ Exec Order 26] as required by order #1. The medical record did not indicate a [NJ Exec Orde] was obtained on [NJ Exec Order 26.4b1] as required by order #2. The medical does not indicate a [NJ Exec Orde] was obtained on NJ Exec Order 26.4b1 as required by order #3. On 9/5/2025 at 10:00 AM, the surveyor interviewed the U.S. FOIA (b)(6) for the [NJ Exec] floor. The [U.S. FO] verbalized [NJ Exec Order] were done at least monthly on all residents and more frequently if ordered. The [U.S. FO] stated that the U.S. FOIA (b)(6) would [NJ Exec Orde] the residents and reports the finding to the [U.S. FO] or to the nurse assigned to the resident. The [U.S. FO] or the [U.S. FOIA (b)] assigned to the resident would record the [NJ Exec Order] in the resident's medical record. On 9/5/2025 at 10:10 AM, the surveyor interviewed the facility's U.S. FOIA (b)(6). The [U.S. F] stated that the [U.S. FOIA (b)] were responsible for obtaining resident [NJ Exec Order 2] and reporting the findings to the [U.S. FO] or the nurse assigned to the resident's care. The [US FO] or the floor nurse recorded the [NJ Exec Order 2] in the resident's medical record after being reviewed by the [U.S. F]. The [U.S. F] acknowledged that following a PO and obtaining [NJ Exec Order] was important for residents who receive [NJ Exec Orde] [NJ Exec Order 26] On 9/5/2025 at 11:00 AM, during an interview with the surveyor, the U.S. FOIA (b)(6) confirmed that a physician's order for a specific [NJ Exec Orde] schedule should be followed accurately. The [U.S. FOIA] acknowledged that monitoring [NJ Exec Order 2] was important in monitoring resident's [NJ Ex Order 26.4(b] status. On 9/9/2025 at 11:10 AM, the surveyor met with [U.S. FOIA (b)(6)] to discuss the above observations and concerns. The U.S. FOIA (b)(6) confirmed that the [NJ Ex Order 26] were not taken per the PO. A review of the facility policy, "Weight monitoring" reflected in section #5 A weight monitoring schedule will be developed upon admission for all residents and… Weights should be recorded at the time they were obtained. NJAC 8:39- 27.2(a)	F0692		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F0695	resident #44 was affected by this deficient practice. The [NJ Exec Order 26.4b1] found inside resident #44 room was removed immediately and placed in the [NJ Exec Orde] storage	11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0695 SS = D	Continued from page 7 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to obtain a physician's order for the administration of [redacted] and failed to ensure that [redacted] equipment was stored in accordance with infection control measures for 1 of 2 residents reviewed for [redacted] care (Resident # 44). This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 09/02/2025 at 12:00 PM, the surveyor observed a [redacted] tank in room [redacted] on the left side of Resident #44's bed. The surveyor observed that the [redacted] was heavily soiled with a brown substance, and the undated [redacted] was on the floor. On 9/2/25 at 12:30 PM, the surveyor observed	F0695	Continued from page 7 room. The undated [redacted] found inside resident #44 room was immediately discarded. All residents have the potential to be affected by this deficient practice. Medical records were audited to ensure that all residents on [redacted] have an active order for [redacted] therapy, and all [redacted] are properly labeled, dated and stored in a plastic bag in accordance with infection measures, following a room-to-room inspection. [redacted] was alerted about the [redacted] inside resident #44's room. Findings were also documented in the pest control book. The DON/Designee initiated an in-service on [redacted] Administration and Proper storage of [redacted]. The [redacted] initiated an in-service on Policy on Pest Control Program, timely notification of pest sightings and how to utilize pest control book. The DON/Designee will conduct a room-to-room inspection of 10 rooms followed by medical record audit to ensure that all residents on [redacted] therapy have an active physician's order and [redacted] are properly labeled and stored in plastic bag for infection control measures. The [redacted] /Designee will check the pest control book daily for new findings identified to ensure timely interventions. Audits will be completed weekly x4 and monthly x3. The result of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0695 SS = D	Continued from page 8 Resident #44 in the 1st floor nursing unit in front of the nurses' station. The resident did not respond to the surveyor's greeting. A review of Resident #44's Admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Exec Order 26.4b1 [redacted] A review of the resident's current Physician Order Summary report reflected that there was no physician's order for the use of [redacted]. A review of Resident #44's annual Minimum Data Set (MDS), an assessment tool, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated NJ Exec Order 26.4b1. Further review of the MDS in Section [redacted] did not indicate that the resident received NJ Exec Order 26.4b1. A review of Resident #44's individualized care plan (ICP) with an initiated date of [redacted]; revised date of [redacted], and a target date of [redacted], that included a focus area that the resident had an NJ Exec Order 26.4b1 status due to NJ Exec Order 26.4b1 with interventions that included but were not limited to; to administer [redacted] as needed per physician order, to monitor NJ Exec Order 26.4b1 and to monitor [redacted] and response. On 9/2/25 at 12:32 PM, during an interview with the surveyor, the U.S. FOIA (b)(6) acknowledged that the NJ Exec Order 26.4b1 was not dated, on the floor, and that the NJ Exec Order 26.4b1 discarded the NJ Exec Order 26.4b1 this morning when she first saw it on the floor. On 9/3/25 at 12:16 PM, during an interview with the surveyor, the [redacted] stated that the resident did not have an order for [redacted] and was not sure why it was in his/her room yesterday. The [redacted] stated that it may have been administered when the resident had [redacted] On 9/9/25 at 12:55 PM, the survey team met with the U.S. FOIA (b)(6) [redacted]) and U.S. FOIA (b)(6) to discuss the above observations and concerns. The [redacted] confirmed that Resident #44 should have had a physician's order for the administration of [redacted] per the resident's ICP and that the [redacted] should be dated and stored in a plastic bag for infection control measures. A review of the facility's policy, Oxygen Administration, dated 5/2025, reflected...Oxygen is administered under the orders of a physician, except in the case of an emergency. In such a case, oxygen is administered and orders for	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0695 SS = D	Continued from page 9 oxygen are obtained as soon as practicable when the situation is under control...The resident's care plan shall identify the interventions for oxygen therapy... 8:39-31.4 (a)	F0695		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following: On 09/02/2025 at 10:30 AM, the surveyor in the presence of the U.S. FOIA (b)(6) toured the kitchen and observed the following: 1. In the reach in refrigerator the surveyor observed 3 blocks of pre-sliced cheese wrapped in plastic film with no open date or use by date and a foil covered plate of breakfast foods with no label, opened or use by date. The U.S. FOIA stated all opened or left over foods	F0812	The three blocks of pre- sliced cheese wrapped in plastic films and a foil-covered plate of breakfast food with no date or use by date were all discarded immediately. The unlabeled tray of souffle cups of individually portioned canned fruits and pureed canned fruits found inside the walk-in cooler were also immediately discarded by the Food Service Director (FSD). The plate covers that were wet nesting were removed by a staff member and rewashed immediately. All residents have the potential to be affected by this deficient practice. The staff responsible for the deficient practice was counseled and an education was completed on the facility policy for Food Safety requirements. In-service on the facility policy "Food Safety Requirements which included practices to maintain safe refrigerated storage including labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so that it is used by it's used by date or frozen (where applicable) and equipment handling was initiated by the FDS for all dietary staff. The FSD will conduct audits to determine compliance to the "food safety requirements policy on proper dating and labeling of stored food and proper equipment handling. Audits will be completed weekly x3 weeks then monthly x2 months. The results of the audit will be reviewed during the monthly QAI meeting.	11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
F0812 SS = F	Continued from page 10 should have a prepared or opened on date and a use by date to prevent residents from receiving spoiled or expired foods. The [U.S. FOIA] confirmed that the unlabeled foods would be discarded. 2. In the walk-in cooler, the surveyor observed a tray of soufflé cups of individually portioned canned fruits and pureed canned fruits. Neither the containers nor the tray was labeled with open dates or use-by dates. The [U.S. FOIA] stated all opened foods should be labeled with opened and use by dates to prevent residents from receiving spoiled or expired foods. The [U.S. FOIA] confirmed that the unlabeled food would be discarded. 3. On a rolling cart near the tray assembly line, the surveyor observed several stacks of plate covers that were wet nested. The [U.S. FOIA] confirmed this cart, and the covers were in place to be used on the upcoming lunch service. The [U.S. FOIA] confirmed that dishware and serving vessels should not be wet nested to prevent the growth of bacteria. The [U.S. FOIA] assigned a staff member to remove the covers for rewashing immediately. On 9/8/2025 at 10:30 AM, the surveyor met with the [U.S. FOIA (b)(6)] to discuss the above observations and concerns. The administration confirmed that all opened and prepared foods need to be labeled with an open date and a use by date to prevent residents from receiving expired or spoiled foods. The [U.S. FOIA] acknowledged that wet nesting of dishes should not occur to prevent bacterial growth. A review of the facility's policy “Food Safety Requirements” dated 9/1/24 revealed... Practices to maintain safe refrigerated storage include labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so that it is used by its use-by date, or frozen (where applicable)/discarded. On 9/10/25 at 1:00 PM, the surveyor team met with the [U.S. FOIA (b)(6)]. No further information provided by the facility. NJAC 8:39-17.2(g)	F0812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061627	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
S0000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 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 THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS	S0000		11/03/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:	S0560	The facility utilizes a corporate Recruiter who is scouting through the local list of CNA to recruit. The facility is aggressive hiring nursing staff to meet state staffing requirements. The facility will facilitate an open house/Job fair event. The facility will post CNA positions with an outside hiring company online to recruit staff. All residents have the potential to be affected by this deficient practice. The Administrator re-educated the staffing coordinator and the DON (Director of Nursing) regarding the appropriate staffing ratio requirements. The staffing coordinator will submit the monthly staffing schedule to the DON/Designee three weeks in advance to review staffing levels to meet the staffing ratio requirement and resolve any staffing issues ahead of time. Daily meeting with the staffing coordinator and the DON/Designee to review weekly and actual schedule to check if staffing ratio is met. The facility has contracts with nursing staffing agencies and has conducted job fairs through the online recruitment platforms as well as traditional recruitment firms. The facility will provide bonus incentives for staff picking up extra shift. The staffing coordinator/designee will conduct a random audit to ensure staffing level are within mandated ratio. All issues identified will be corrected immediately. The audits will be conducted weekly x4 and monthly x2 months. The results of the audit will be reviewed	11/03/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061627	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
S0560	Continued from page 1 (1) one certified nurse aide to every eight residents for the day shift. (2) 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 staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) 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 b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the two weeks of staffing from 8/17/25	S0560	Continued from page 1 during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061627	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
S0560	Continued from page 2 through 8/30/25 prior to the Standard survey of 9/9/25 revealed the facility was deficient in CNA staffing for residents on 11 of 14-day shifts as follows: -08/17/25 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/18/25 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/20/25 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/21/25 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/22/25 had 12 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/23/25 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/24/25 had 11 CNAs for 102 residents on the day shift, required at least 13 CNAs. -08/25/25 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/26/25 had 9 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/28/25 had 11 CNAs for 104 residents on the day shift, required at least 13 CNAs. -08/30/25 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs. On 9/8/25 at 9:40 AM, during an interview with the surveyor, the staffing coordinator stated that she was aware of the staffing requirements. She further stated that several of their per diem CNAs resigned, so it was difficult to meet the CNA-to-resident ratios. On 9/8/25 at 10:03 AM, the survey team discussed the above observations and concerns with the Licensed Nursing Home Administrator, Director of Nursing and Regional Nurse. A review of the facility's staffing policy reflected…the facility maintains adequate staffing on	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061627	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
S0560	Continued from page 3 each shift to ensure that residents' needs and services are met.	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055**

(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
F0000	INITIAL COMMENTS An offsite/desk review of the facility's plan of correction was conducted on 8/20/25 in relation to the 9/9/25 recertification survey. The facility was found to be in compliance with 42CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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 reverse for further 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.

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061627	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
S0000	Initial Comments An offsite/desk review of the facility's plan of correction was conducted on 8/20/25 in relation to the 9/9/25 recertification survey. The facility was found to be in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long-Term Care Facilities .	S0000		

Office of Primary Care and Health Systems Management

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
K0000	INITIAL COMMENTS A Life safety code Survey was conducted by the New jersey Department of Health, Health Facility Survey and Field Operations on 09/03/2025, 09/04/2025 and 09/05/2025, and Complete Care at Hamilton was found to be in non-compliance 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 Occupancies. The facility is a 2- story building, with a basement that was built in 1984. It is composed of Type II protected construction. The facility is divided into 6-smoke zones. The facility has a 125 KW diesel emergency generator.	K0000		11/03/2025
K0271 SS = E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This STANDARD is NOT MET as evidenced by: REPEAT DEFICIENCY Based on observation and review of facility provided documentation on 09/03/2025 and 09/04/2025 in the presence of the facility U.S. FOIA (b)(6) , it was determined that the facility failed to provide 1 of 5 exit discharges with a stable, hard packed all-weather travel surface and maintain a level walking surface, free of all obstructions and impediments to reach a public way (street or parking lot) in the case of a fire or other emergency in	K0271	No residents or staff were affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The U.S. FOIA (b)(6) was in-serviced by the U.S. FOIA on facility policy on Discharges from exits having a stable hard packed all weather travel surface, free of all obstructions and impediments. Quotes obtained for repair and repair will be completed by 10-29-25. U.S. FOIA (b)(6) to audit Discharge from exit have stable hard packed, all weather travel surface, free of all obstructions and impediments once repair is completed weekly x4 and monthly x3. The result of the audit will be discussed during the monthly QAPI meeting.	11/03/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
K0271 SS = E	Continued from page 1 accordance with the National Fire protection Association (NFPA) 101, 2012 edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. This deficient practice had the potential to affect limited residents and was evidenced by the following: A review of the facility lay-out identified the facility is a two-story (2) building with a basement. There are five (5) designated exit discharge doors (Illuminated exit signs above the doors) that Residents, Visitors and Staff would use in the event of an emergency to exit the building. Observations on 09/03/2025: At approximately 10:00 AM, an inspection outside the designated exit discharge door near the Commercial Laundry room revealed a 19-foot-long grassy sloped unstable walking surface to reach a public way (sidewalk/ parking lot). The U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit on 09/05/2025 at approximately 12:30 PM. This deficient practice was cited on the Recertification survey dated 06/27/2024. NJAC 8:39 -31.2 (e)	K0271		
K0355 SS = F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observations and interview on 09/03/2025 and 09/04/2025 in the presence of the facility U.S. FOIA (b)(6) , it was determined that the facility failed to perform Six (6) Year Maintenance and /or Hydro testing for 12 of 17 portable fire	K0355	No residents were affected by this deficient practice. The DOM hired a company to conduct/perform the six-year maintenance/hydro testing for the twelve fire extinguishers in accordance with the NFPA 10. This was completed on 09.04.2025 All residents have the potential to be affected by this deficient practice. The RMD and the Administrator in-serviced the U.S. FOIA and the Assistant on facility policy on Portable fire extinguishers. The DOM will conduct an audit of 5 fire extinguishers to determine compliance to policy on Portable fire extinguishers weekly x4 and monthly x2. The result of the audit will be reviewed during the monthly QAPI meeting	11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
K0355 SS = F	Continued from page 2 extinguishers in accordance with NFPA 10. This deficient practice had the potential to affect the 107 residents and was evidenced by the following: Observations during the two (2) day building tour (09/03/2025 and 09/04/2025) in the presence of the facility[U.S. FOIA] revealed seventeen (17) portable fire extinguishers in various locations with the following results: On the basement level, the surveyor observed Six (6) fire extinguishers with 6-year maintenance collars attached to the extinguishers that were last inspected May 2019 and One (1) fire extinguisher with a 6-year maintenance collar that was inspected April 2011. On the 2nd. floor level, the surveyor observed Two (2) fire extinguishers with a 6-year maintenance collar attached to the extinguishers that were last inspected May 2019 and One (1) fire extinguisher with a 6-year maintenance collar that was last inspected September 2016. On the 1st. floor level, the surveyor observed One (1) fire extinguisher with a 6-year maintenance collar attached to the extinguisher that was last inspected September 2016 and One (1) fire extinguisher with a 6-year maintenance collar that was last inspected May 2019. In an interview, the[U.S. FOIA] confirmed the findings during the times of observations. The[U.S. FOIA (b)(6)] were informed of the deficient practice during the Life Safety Code survey exit on 09/05/2025 at approximately 12:30 PM. NJAC 8:39-31.1 (c), 31.2 (e) NFPA 10	K0355		
K0374 SS = E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K0374	The DOM immediately hired a company to repair the 1 1/8-inch gap along the bottom edge of the smoke door of the corridor double door near room #[NJ Exac] and the repair was completed on 09/08/2025 All residents have the potential to be affected by this deficient practice.	11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
K0374 SS = E	Continued from page 3 Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observations, interview and review of facility provided documentation on 09/03/2025 and 09/04/2025 in the presence of the facility U.S. FOIA (b)(6) it was determined that the facility failed to maintain smoke barrier doors to resist the transfer of smoke when completely closed for fire and smoke protection. This deficient practice was identified for 1 of 4 sets of corridor double smoke barrier doors tested in accordance with Life Safety Code 101, 2012 Edition, 19.3.7.6,19.3.7.8, 19.3.7.9 and 8.5.4.1. This deficient practice had the potential to affect all residents on the 2nd. floor and was evidenced by the following: A review of the facility provided lay-out identified the facility was a two-story building with a basement. There were six (6) smoke zones with four (4) sets of corridor double smoke doors. Observations on 09/03/2025 reveled the following: At approximately 10:27 AM, during a closure test of the corridor double smoke doors next to Resident room NJ Exec C, the surveyor observed, measured and recorded a 1-1/8 inch gap along the bottom edges of the smoke doors. In an interview at the time, the U.S. FOIA confirmed the findings. The U.S. FOIA (b)(6) were informed of the deficient practice during the Life Safety Code survey exit at approximately 12:30 PM on 09/05/2025.	K0374	Continued from page 3 The Administrator educated the U.S. FOIA (b)(6) on the facility policy on smoke barrier doors. Maintenance Director to audit a closure test on all corridor smoke doors for fire and smoke protection. To be done weekly x 4 and monthly x3. The result of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
K0374 SS = E	Continued from page 4 NJAC 8:39 -31.1 (c), -31.2(e)	K0374		
K0923 SS = D Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observations and interview on 09/03/2025 in the presence of the facility U.S. FOIA (b)(6) [redacted] it was determined that the facility	K0923	The two E-type oxygen cylinders stored upright on the floor on the second floor and were not placed in a secured storage unit were secured immediately to prevent them from accidentally tripping over and rupturing. All residents have the potential to be affected by this deficient practice. The U.S. FOIA (b)(6) [redacted] was in-serviced by the Regional Maintenance Director on facility policy on Oxygen safety, (which includes how to secure portable oxygen cylinders stored to prevent accidental tripping and rupturing in accordance with NFPA 99:2012 edition). The maintenance Director/ designee will audit two Oxygen storage locations weekly to ensure that all oxygen cylinders are secured. Audits be done weekly x4 and monthly x2. Result of the audit will be discussed during the monthly QAPI meeting.	11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
K0923 SS = D Bldg. 01	Continued from page 5 failed to secure portable oxygen cylinders to prevent accidental tipping and rupturing in accordance with NFPA 99: 2012 edition. This deficient practice had the potential to affect all residents on the second floor and was evidenced by the following: Observations during the building tour in the presence of the [redacted] at approximately 10:27 AM inside the second floor oxygen storage room, revealed two (2) E-Type oxygen cylinders stored up-rite on the floor and were not placed in a secured storage unit or secured by a wall mounted chain to prevent them from accidentally tipping over and rupturing. In an interview, the [redacted] confirmed the finding at the time of observation. The [redacted] were informed of the deficient practice during the Life Safety Code survey exit at approximately 12:30 PM on 09/05/2025. NJAC 8:39-31.2 (e) NFPA 99	K0923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055**

(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
E0000	Initial Comments An Emergency Preparedness survey was conducted on 09/03/2025, 09/04/2025 and 09/05/2025 and Complete Care Hamilton was found to be in NON-COMPLIANCE with Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		11/03/2025
E0004 SS = E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E0004	Pages 6 (six) and 7 (seven) of the EPP (Emergency Preparedness Plan) were corrected on 09/05/2025 with Admin #1's name and All EPP books were updated with the copy of the corrected EPP (with the name of Admin#1) All residents have the potential to be affected by this deficient practice. The U.S. FOIA (b)(6) and the U.S. FOIA (b)(6) were in-serviced by the (RMD) Regional Maintenance Director on the facility policy on Emergency Preparedness Plan. The Administrator/Designee will audit the EPP books weekly x4 and monthly x2 to ensure that the EPP book is updated. The result of the audit will be reviewed during the monthly QAPI meeting.	11/03/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
E0004 SS = E	Continued from page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is NOT MET as evidenced by: Based on Interview and documentation review on 09/03/2025, 09/04/2025 and 09/05/2025 in the presence of the facility Administrator #1 (Admin. #1) and U.S. FOIA (b)(6) it was determined that the facility failed to ensure that the Emergency Preparedness Plan (EPP) were reviewed and updated at least annually. This deficient practice had the potential to affect the 107 Residents in the facility and was evidence by the following: In an Interview during the survey entrance on 09/03/2025 at approximately 9:17 AM, a request was made to the Admin. #1 and U.S. FOIA "How many Emergency Preparedness Plan (EPP) books are in the facility?". The surveyor also asked the Admin. #1 to provide a list of all employees that include the Date of Hire, Job Title and Hours of work. The U.S. FOIA told the surveyor that there are four (4) EPP books in the facility, 1 at the second floor Nurses station, 1 at the first floor Nurses Station, 1 at the Receptionists desk and the U.S. FOIA has 1 book. On 09/04/2025, a review of the RMD EPP book read in part: "Emergency Preparedness Manual has been reviewed with the IDT team on July 31, 2025, at 10:00 AM." With the following signatures. Admin. #U.S. FOIA (b)(6) . Comprehensive Emergency Preparedness Plan Updated 07/10/2025 Page 6 read in part: This plan has been reviewed and promulgated on 05/23/2024 by Administrator #2 (Admin. #2). Updated 07/10/2025 Page 7 read in part: Policy Statement, The emergency preparedness plan shall be reviewed and updated at	E0004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
E0004 SS = E	Continued from page 2 least annually. The Administrator, Admin. #2 shall serve as the Emergency Preparedness Planner. Updated 07/10/2025. Page 17 read in part: If the required medication still cannot be located, notify the Administrator, Admin. #2. On 09/05/2025, a review of the First floor Nurses Station EPP book reads in part: "Emergency Preparedness Manual has been reviewed with the IDT team on July 31, 2025 at 10:00 AM." With the following signatures, Admin. #1, U.S. FOIA (b)(6) [redacted] Comprehensive Emergency Preparedness Plan Updated 07/10/2025 Page 6 read in part, This plan has been reviewed and promulgated on 05/23/2024 by Administrator #2 (Admin. #2). Updated 07/10/2025 Page 7 read in part, Policy Statement, The emergency preparedness plan shall be reviewed and updated at least annually. The Administrator, Admin. #2 shall serve as the Emergency Preparedness Planner. Updated 07/10/2025. Page 17 read in part, If the required medication still cannot be located, notify the Administrator, Admin. #2. A review of the facility provided list of employees identified that Admin. #1 started working at the facility on 06/30/2025. The Admin. #1 and the U.S. FOIA [redacted] confirmed the finding. The Admin. #1 and the U.S. FOIA [redacted] were informed of the deficient practice during the Life Safety Code survey exit at approximately 12:30 PM, on 09/05/2025. NJAC 8:39-31.2 (e)	E0004		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055

(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
K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/24/2025 in relation to the 09/09/2025 Life Safety Code survey. The facility was found to be in compliance 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.	K0000		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315221	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE , PASSAIC, New Jersey, 07055**

(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
E0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/24/2025 in relation to the 09/09/2025 Emergency Preparedness survey. The facility was found to be in compliance with the requirement for participation in Medicare/Medicaid at 42 CFR, Subpart 483.73, Emergency Preparedness.	E0000		

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 reverse for further 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.

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