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

PRINTED: 09/24/2020 FORM APPROVED OMB NO. 0938-0391

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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		315221	B. WING			07/	28/2020
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
COMPLET	E CARE AT HAMILTON,	LLC		؛	56 HAMILTON AVENUE		
COWIFLE	E CARE AT HAWILTON,	LLC			PASSAIC, NJ 07055		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	NEGOL/WORT ORT		170		DEFICIENCY)		
F 000	INITIAL COMMENTS	;	F	000	)		
	COMPLAINT# NJ 1	33324					
	CENSUS: 70						
	SAMPLE SIZE: 4						
	THE FACILITY IS IN	COMPLIANCE WITH THE					
	REQUIREMENTS OF						
	SUBPART B, FOR LO						
		ON THIS COMPLAINT					
	VISIT.						
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	<del>_</del> E		TITLE		(X6) DATE

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.

**Electronically Signed** 

08/25/2020

New Jersey Department of Health

NAME OF PROVIDER OR SUPPLIER  COMPLETE CARE AT HAMILTON, LLC  S6 HAMILTON AVENUE PASSAIC, NJ 07055  (X4) ID FROVIDER'S (EACH DEFICIENCY MUST BE PRECEDED BY PLLL REGULATORY OR LSC (DENTIFYING INFORMATION))  S1680	AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  S6 HAMILTON AVENUE PASSAIC, NJ 07055  PROVIDERS PLAN OF CORRECTION  (PAJID RECENT OF PROVIDER OF SUBMARY STATEMENT OF DEPICIENCIES PASSAIC, NJ 07055  (PAJID RECENT OF PROVIDER OF PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY DIATE  S1680 8:39-25.2(b)(1)8(2) Mandatory Nurse Staffing  (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of:  1. Total number of residents multiplied by 2.5 hours/day; plus  2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:  Wound care  0.75 hour/day  Nasogastric tube feedings and/or gastrostomy  1.00 hour/day  Oxygen therapy  0.75 hour/day  Tracheostomy  1.25 hours/day  Intravenous therapy  1.50 hours/day  Use of respirator  1.25 hours/day  Use of respirator  1.25 hours/day				C				
COMPLETE CARE AT HAMILTON, LLC  SOUNDARY STATEMENT OF DEPICENCING  (EACH DEFICIENCY MUST BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION)  S1680  S16			061627	B. WING				
COMPLETE CARE AT HAMILTON, LLC  (A4 ID PREFIX IT AG  (BACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  S1680  8:39-25.2(b)(1)8(2) Mandatory Nurse Staffing  (b) The facility shall provide nursing services by registered professional nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of:  1. Total number of residents multiplied by 2.5 hours/day; plus  2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:  Wound care  0.75 hour/day  Nasogastric tube feedings and/or gastrostomy  1.26 hours/day  Intravenous therapy  1.50 hours/day  Use of respirator  1.25 hours/day  Use of respirator  1.25 hours/day  Use of respirator  1.25 hours/day	NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE			
(A) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  S1680 8:39-25.2(b)(1)8(2) Mandatory Nurse Staffing  (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct are hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of:  1. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day:  Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 1.50 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Use of respirator 1.25 hours/day Use of respirator	56 HAMILTON AVENUE							
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Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day		registered professional nurses, and nurse aid of nursing are not incleased for the direct of nursing in facilities who provides more than that N.J.A.C. 8:39-25.10  1. Total number of hours/day; plus  2. Total number of service listed below, recorresponding nursers with the distriction of the distr	al nurses, licensed practical les (the hours of the director luded in this computation, leare hours of the director of licere the director of nursing lice minimum hours required (a) above) on the basis of:  of residents multiplied by 2.5  of residents receiving each multiplied by the lumber of hours per day:  tube feedings and/or 1.00 hour/day lapy  therapy lay rator lay a stimulation/advanced					

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

(X6) DATE TITLE

08/25/20

**Electronically Signed** STATE FORM 6899

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New Jers	New Jersey Department of Health							
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					C			
		061627	B. WING		07/28/2020			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE. ZIP CODE	-			
		56 HAMIL	TON AVENUE	,				
COMPLET	E CARE AT HAMILTON,	PASSAIC	, NJ 07055					
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S1680	Continued From page	÷ 1	S1680					
	This REQUIREMENT is not met as evidenced by: COMPLAINT # 133324  Based on interview and review of the Nurse Staffing Report from the week of 2/9/2020, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 7 days.  The required staffing hours, and actual staffing hours are as follows:  For the week of 2/9/2020 Required staffing hours: 280.00  Date 2/9/2020 Actual Hours 264 Difference -16.00  During a post survey telephone interview on 8/13/2020 at 2:08 p.m., the Administrator stated that when the facility has call outs they have several different agencies they can use, also the facility will see if someone wants to work a double shift.			How the corrective action will be accomplished for those residents four have been affected by the deficient practice:  1. Nursing Staffing Process reviewed including ensuring required and actual nursing staffing hours match to reflect acuity.  How the facility will identify other residents having the potential to be affected by the deficient practice:  1. All the residents of the Center (Complete Care @ Hamilton Plaza) has the potential to be affected by the deficient practice.  What measures will be put in place or systemic changes were made to ensurthat deficient practice will not recur:  1. DON/Designee in-serviced Facility Staffing Coordinator and Nursing	I the			
				Staffing Coordinator and Nursing Administrative Staff on Nursing Staffin				

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	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	COMPLE		TED		
					c			
		061627	B. WING		1	8/2020		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
COMPLET	TE CARE AT HAMILTON,	LLC PASSAIC, I	ON AVENUE					
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S1680	Continued From page	e 2	S1680					
				hours match, reflect the acuity. Initial Audit conducted for compliance.				
				How facility will monitor it's corrective actions to ensure that the deficient practice is being corrected and will no recur. I.E. what program will be put in place to monitor the continued effectiveness of the systemic change:  1.The DON/designee will conduct dail staffing and Acuity report audit. It will completed daily x 14 days then weekly there after x 3 months. Negative trend will be corrected immediately. Result of the audit will be reviewed/presented (at the monthly QAPI committee meeting)	y be y Is of			