

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061627	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/08/2022
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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT HAMILTON, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 56 HAMILTON AVENUE PASSAIC, NJ 07055
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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S 000	<p>Initial Comments</p> <p>Initial Licensure Survey for their Behavioral Health Unit was conducted on 8/8/22.</p> <p>The facility is in substantial compliance with all of the standards in the New Jersey Administrative Code, Chapter 8:85-2.1-2.21 standards for Behavioral Health Nursing Facility for Long Term Care.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/10/22