STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE PASSAIC, NJ 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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #s NJ 172883, 172883a, 173284, 173284a, 173284b, 173367, 173367a, 173367b, 173545, 173545a, 173545b, 173772, 173772a, 173872a, 174222, 174242, 174242a STANDARD SURVEY: 6/23-6/27/24 CENSUS: 99 SAMPLE SIZE: 25+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 712		8/14/24

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

Electronically Signed | 07/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 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
F 712	Continued From page 1 §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined that the facility failed to ensure that the responsible US FOIA (B) (6) supervising the care of residents conducted face to face visits and wrote progress notes at least once every sixty days. This deficient practice was identified for 1 of 25 residents, Resident #45 was reviewed for physician visits and was evidenced by the following: On 6/23/24 at 10:59 AM, the surveyor observed Resident #45 lying in bed who was noted to be NJ Ex Order 26.4b1. On 6/24/24 at 9:33 AM, the surveyor reviewed the Admission Record for Resident #45 which revealed the resident was admitted to the facility with diagnoses that included but were not limited NJ ex order 26.4b1 [redacted]	F 712	1. Resident #45 was affected by the deficient practice. US FOIA (B) (6) was in-serviced, came in and completed the NJ ex order 26.4b1. 2. All residents have the potential to be affected by this deficient practice. 3. The Director of Nursing in-serviced the US FOIA (b)(6) on visiting and examining residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. 4. The director of Nursing/Designee will audit 10 resident charts weekly x 4 weeks and then monthly x 2 months to ensure that physician visits and documentatio are compliant. Results will be rviewed at the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 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
F 712	Continued From page 2	F 712		

A review of the Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that Resident #45 had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, indicating [redacted].

A review of the physician's progress notes reflected there was no documented evidence that the physician visited and examined Resident #45 at least [redacted] from [redacted].

On 6/26/24 at 11:10 AM, the surveyor interviewed the [redacted] on the first floor, [redacted] who has been working in the facility for [redacted]. The [redacted] stated, "The last progress note from the primary doctor was [redacted]. Notes were done for [redacted] and [redacted], but [redacted], [redacted] I didn't see any notes from the doctor in the computer or the chart. [redacted] does not see this patient."

On 6/26/24 at 11:30 AM, the surveyor interviewed the [redacted], regarding physician visits, she stated, "The doctor comes in and visits his patients frequently and he just started documenting in the computer." The surveyor requested to provide documentation of any notes from the doctor from [redacted].

On 6/26/24 at 12:50 PM, the [redacted] acknowledged in the presence of the survey team that Resident's #45 physician did not complete progress notes for [redacted]. The facility did not provide any additional documentation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE PASSAIC, NJ 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
F 712	Continued From page 3 On 6/26/24 at 1:15 PM, the survey team discussed the above concern with the facility's US FOIA (B) (6) US FOIA (B) (6) of US FOIA (B) (6) , and two Regional of Clinical Services. On 6/27/24 at 9:25 AM, the surveyor reviewed the most current facility policy and procedure titled, "Physician Visits" which revealed, "The Attending Physician must make visits in accordance with applicable state and federal regulations." NJAC 8:39-23.2 (d)	F 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061627	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 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) COMPLETE DATE
S 000	Initial Comments Complaint NJ001173367 The facility is 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint NJ00165012 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. 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	S 560	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. The scheduling Manager and the Nursing management were reeducated/re-in-serviced by the Administrator regarding the appropriate staffing ratio requirements. The staffing scheduler will submit the Completed Monthly Staffing Schedule to the DON/designee two weeks in advance to review staffing levels meet the staffing	8/14/24

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

Electronically Signed | 07/08/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061627	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 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) COMPLETE DATE
S 560	Continued From page 1 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: (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	S 560	ratio requirement and resolve any staffing issues ahead of time. Daily meeting with the scheduler and the DON/designee to review weekly and actual schedule to check if staffing ratio is met. The facility has conducted job fairs and has contracts with nursing staffing agencies. The facility has also advertised open jobs through the online recruitment platforms as well as traditional recruitment firms. Provide bonus incentives for staff doing extra shift. 4. The scheduling Manager/designee will audit weekly x4 weeks and monthly x2 to ensure staffing levels are within the mandated ratio. All identified issues will be corrected immediately. The results of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061627	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 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) COMPLETE DATE
S 560	Continued From page 2 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 "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks of staffing prior to the 6/27/24 Standard Recertification Survey from 6/9/24 to 6/22/24 revealed this deficient practice was evidenced by the following: The facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -06/09/24 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs. -06/16/24 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks of staffing from 6/18/23 to 6/24/23 related to a Complaint Investigation Survey revealed the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061627	A. BUILDING: _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 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) COMPLETE DATE
S 560	Continued From page 3 following deficient practices: The facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -06/18/23 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -06/19/23 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. On 6/27/24 at 9:30 am the surveyor reviewed the facility's Staffing policy and procedure, revised April 2007. Statement 1 indicated the facility maintains adequate staffing on each shift to ensure that resident's needs and services are met. On 6/27/24 at 11:30 am the surveyor discussed staffing concerns with the Administrator, Director of Nursing, and other administrative staff.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315221	A. Building B. Wing	8/21/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 07055

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0712 Reg. # 483.30(c)(1)-(4) LSC	Correction Completed 08/14/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
6/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
061627		8/21/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 07055

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/14/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
6/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 06/24/2024 and 06/25/2024, and Complete Care at Hamilton was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy 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 generator does approximately 80% of the building. The facility has 120 certified beds. At the time of the survey the Long Term Care census was 52 and the Behavior Health census was 47.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the	K 222		8/14/24

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

Electronically Signed | 07/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 222	Continued From page 1 rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 222	Continued From page 2 Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 06/24/2024 and 06/25/2024, it was determined that the facility failed to provide 1 of 5 designated exit access /discharge (illuminated exit signs above door) doors with-in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. Findings include: On 06/24/2024 (day one of survey) during the survey entrance at approximately 9:06 AM, a request was made to the US FOIA (B) (6) and US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with basement. There are five (5) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building.	K 222	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (B) (6) educated that designated access doors with means of egress are readily accessible and free of obstructions or impediments to full instant use in case of fire or other /emergencies. Thumb turn lock to be removed, part ordered and will be replaced by 07/22/2024. 4. Maintenance Director/designee to ensure lock is removed and there is no obstructions or impediments on the designated exit discharge doors. Door to be audited weekly x4 and then monthly x2 months. Results of the audit will be reviewed during during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 222	Continued From page 3 Starting at approximately 9:15 AM on 06/24/2024 and continued on 06/25/2024, in the presence of the US FOIA (B) (6) a tour of the facility was conducted. On 06/25/2024 at approximately 10:30 AM, the surveyor observed the main entrance (illuminated exit sign above the doors) automatic front doors revealed a thumb turn lock on the egress side of the doors. The thumb turn lock and fastening device on the door could restrict emergency use of the designated exit discharge doors. A review of an emergency evacuation diagram posted in the corridor identify the front doors are the primary doors to reach an exit discharge door in the event of an emergency. The US FOIA (B) (6) confirmed the findings at the time of observation. The US FOIA (B) (6) and US FOIA (B) (6) were informed of the Life Safety Code deficiency during the survey exit on 06/25/2024 at approximately 12:20 PM. NJAC 8:39 -31.2 (e) NFPA 101 2012 - 7.2.1.6.1 (4).	K 222		
K 271 SS=D	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 REQUIREMENT is not met as evidenced	K 271		8/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 271	Continued From page 4 by: Based on observation and review of facility provided documentation on 06/24/2024 and 06/25/2024 in the presence of facility management, 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 fire or other emergency in accordance with 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. and the New Jersey Uniform Construction Code 5:23. This deficient practice was evidence by the following: Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or	K 271	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) educated on exit discharges having a stable, hard packed all weather travel surface, free of all obstructions and impediments. Quotes obtained for repair and will be completed by 08/14/2024. 4. Maintenance Director to audit exit discharges have a stable hard packed, all weather travel surface, free of all obstructions and impediments once repair is completed weekly x4 and then monthly x2 months. Results of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 271	Continued From page 5 listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 06/24/2024 (day one of survey) during the survey entrance at approximately 9:06 AM, a request was made to the US FOIA (B) (6) and US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with basement. There are five (5) designated exit discharge doors (illuminated exit signs above doors) that Resident, Staff and Visitors would use in the event of an emergency to exit the building. Starting at approximately 9:15 AM on 06/24/2024 and continued on 06/25/2024, in the presence of the US FOIA (B) (6) a tour of the facility was conducted. On 06/24/2024 during the building tour at approximately 10:00 AM an inspection of a Basement designated exit (illuminated exit signs above the door) discharge door next to the Laundry room was performed. The surveyor observed, measured and recorded a 19 foot long grassy sloped unstable walking surface to reach a public way (sidewalk). A review of the facility provided lay-out identified that there are two designated exit discharge doors (illuminated exit signs above the doors) out of the basement that Staff would use to lead you out of the building in the event of an emergency	K 271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 271	Continued From page 6 to reach a public way. The US FOIA (B) (6) confirmed the findings at the time of observation. The Administrator and US FOIA (B) (6) were informed of the Life Safety Code deficiency during the survey exit on 06/25/2024 at approximately 12:20 PM. Fire Safety Hazard. NJAC 8:39-31.1(e) NFPA 101:2012 - 7.7 NFPA 101:2012- 19.2 Means of Egress Requirements	K 271		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops	K 321		8/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 321	Continued From page 7 d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 06/24/2024 and 06/25/2024, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 8 fire-rated doors inspected to hazardous areas were separated by smoke resisting partitions in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practiced was evidenced by the following: On 06/24/2024 (day one of survey) during the survey entrance at approximately 9:06 AM, a request was made to the US FOIA (B) (6) and US FOIA (B) (6) US FOIA (B) (6)) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with a basement. Starting at approximately 9:15 AM on 06/24/2024 and continued on 06/25/2024, in the presence of the facility's US FOIA (B) (6) an inspection tour of the building was conducted. During the two (2) day building tour the surveyor	K 321	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (B) (6) was educated on gap size between meeting edges of fire door. Door fixed on the day of notification of non-compliance. 4. Maintenance Director to audit fire door to commercial laundry room to ensure no gaps noted between lower meeting edges monthly x3 months. Result of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 321	Continued From page 8 observed the following hazardous area that failed to have smoke resisting doors, On 06/24/2024: 1) At approximately 9:51 AM, during an inspection of the basement level commercial laundry room when the corridor double doors were opened to a 90 degree opening and allowed to self-close into the frame. The surveyor observed, measured and recorded an approximately 1/2" gap by approximately 6 inches between the lower meeting edges. This closure test was repeated two additional times with the same results. With this corridor doors not smoke resistant, this would allow fire, smoke and poisonous gases to pass into the exit access corridor in the event of a fire. The Commercial Laundry room was larger than 100 square feet. A review of an emergency evacuation diagram posted on the corridor wall identified to pass the commercial laundry room is the primary and/ or secondary exit access to reach an exit. The US FOIA (B) (6) confirmed the findings at the time of observation. US FOIA (B) (6) were informed of the Life Safety Code deficiency during the survey exit on 06/25/2024 at approximately 12:20 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation	K 341		8/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 341	Continued From page 9 A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 06/24/2024 and 06/25/2024, in the presence of the facility management, it was determined that the facility failed to provide fire alarm notification by audible and visible signals for 1 of 1 second floor outside Residents Smoking deck area in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice could effect all Residents who reside on the 2nd. floor and was evidenced by the following: On 06/24/2024 (day one of survey) during the survey entrance at approximately 9:06 AM, a request was made to the facility US FOIA (b)(6) [redacted] o provide a copy of the facility lay-out	K 341	1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (B) (6) was educated on need for audio and visual alarm that is tied to the building's fire alarm system. Fire company to add visual alarm to second floor smoking deck by 80/12/2024. 4. Maintenance Director to audit audio and visual alarm to second floor smoking deck is in place and functioning monthly x3 months once installed. Results of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 341	Continued From page 10 which identifies the various rooms and smoke compartments in the facility. The surveyor also requested if the facility had a Memory Impaired (Secured) Unit. The US FOIA (B) (6) told the surveyor the second floor is a secured unit. A review of the facility provided lay-out identified the facility is a two-story (2) building with a basement. There 25 Resident sleeping rooms, common areas on the 1st. floor and 26 Resident sleeping rooms, common areas on the 2nd. floor Secured Unit. Starting at approximately 9:15 AM on 06/24/2024, in the presence of the facility's US FOIA (B) (6), an inspection tour of the building was conducted. At approximately 11:01 AM, an inspection of the second floor Secured Units outside Residents smoking deck area was performed. The surveyor observed the Residents smoking area deck had an approximately 4'- 6" high fence. There were no stairs leading from the deck down to a public way. The surveyor observed no evidence of an audio and visual alarm that is tied into the buildings fire alarm and detection system. At this time, the surveyor asked the US FOIA (b)(6), "Does the facility have an audio and visual alarm that is tied into the buildings fire alarm and detection system to alert Residents and Staff who come out here?" The US FOIA (B) (6) told the surveyor, No. The US FOIA (B) (6) confirmed the finding at the time of observation.	K 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 341	Continued From page 11 The US FOIA (b)(6) were informed of the Life Safety Code deficiency during the survey exit on 06/25/2024 at approximately 12:20 PM. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 06/24/2024 and 06/25/2024, in the presence of facility management it was determined that: The Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section	K 351	1. No residents or staff were affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (B) (6) educated on fire	8/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 351	Continued From page 12 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 06/24/2024 (day one of survey) during the survey entrance at approximately 9:06 AM, a request was made to the US FOIA (B) (6) and US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with a basement. There are three (3) designated exit stairwells (illuminated exit signs above doors) that Resident, Visitors and Staff would use in the event of an emergency /fire to reach an exit discharge door. Starting at approximately 9:15 AM on 06/24/2024 and continued on 06/25/2024, in the presence of the US FOIA (B) (6) a tour of the facility was conducted. Along the two day tour the surveyor observed the following: 1) On 06/24/2024 at approximately 9:36 AM, the surveyor observed, measured and recorded inside the basement stairwell a 4 feet by 11 feet lower landing area that had no evidence of fire sprinkler coverage. At this time the surveyor asked the US FOIA (b)(6), "Do you see any sprinklers at this landing level." The US FOIA (B) (6) looked up and around and told the	K 351	sprinkler coverage inside stairwells at top of landing and on every other floor in between. Quote obtained from sprinkler company and sprinkler to be installed by 08/12/2024. 4. Maintenace director to audit sprinklers inside stairwells, at top of landing and bottom of landing and on every other floor once sprinkler is added monthly x3 months. Results of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 351	Continued From page 13 surveyor, no. The surveyor also observed evidence of a penetration through the masonry wall and asked the US FOIA (B) (6) to go into the adjacent room where the hole in the masonry wall is located. Both US FOIA (B) (6) and surveyor observed inside the adjacent storage room evidence of a sprinkler pipe leading towards the stairwell wall with a plug in the end of the pipe along with evidence of the masonry wall had been repaired. Code requires fire sprinkler coverage inside stairwells at the top landing , bottom landing and every other floor in between. The US FOIA (B) (6) confirmed the findings at the time of observation. The US FOIA (b)(6) were informed of the Life Safety Code deficiency during the survey exit on 06/25/2024 at approximately 12:20 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 355 SS=D	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 REQUIREMENT is not met as evidenced by: Based on observation and review of facility	K 355	1. No residents were affected by this	8/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 355	Continued From page 14 documentation on 06/24/2024 and 06/25/2024 in the presence of facility management, it was determined that the facility failed to: 1) Perform a monthly examination for 1 of 15 portable fire extinguishers observed and inspected. 1) Maintain 1 of 15 portable fire extinguishers inspected in proper working condition, as required by National Fire Protection Association as required by NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads, - 4- 3 Inspection Maintenance. - 4- 3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4- 3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4- 3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following,	K 355	deficient practice. 2. All residents have potential to be affected by this deficient practice. 3. US FOIA (B) (6) in serviced on documetation of monthly visual fire extinguisher examination and replacement of extinguisher when pressure is in the "red" discharge zone. Fire extinguishers examined and all within compliance. Fire extinguisher in "red" discharge zone was replaced at the time of notification. All other fire extinguisher were checked and within compliance. 4. Maintenance Director/designee will audit fire extinguisher weekly x4 weeks then monthlyx2 months to ensure monthly visual inspection is completed and pressures are not in the "red" discharge zone. Results of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 355	Continued From page 15 On 06/24/2024 (day one of survey) during the survey entrance at approximately 9:06 AM, a request was made to the f[redacted] and [redacted] to provide a copy of the facility lay-out which identifies the various rooms. A review of the facility provided lay-out identified the facility is a two-story (2) building with a basement. There are 25 Resident sleeping rooms and common areas on the first floor. There are 26 Resident sleeping rooms and common areas on the second floor. Starting at approximately 9:15 AM on 06/24/2024 and continued on 06/25/2024, in the presence of the facility's [redacted], an inspection tour of the building was conducted. Along the two (2) day tour the surveyor observed and inspected fifteen (15) fire extinguishers in various locations that were last annually inspected March 2024 with the following issues that were identified: On 06/24/2024: 1) At approximately 11;01 AM, One (1) "ABC-Type" fire extinguisher on the second floor Residents outside smoking deck area was last annually inspected March 2024. There was no evidence of monthly visual examination performed and documented on the tag attached to the extinguisher for April and May 2024. On 06/25/2024: 2) At approximately 10:32 AM, on the first floor next to the Business office was one (1)	K 355		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 355	Continued From page 16 "ABC-Type" fire extinguisher's pressure indicating needle was in the "RED" discharge zone on the pressure gauge on the fire extinguisher. At this time a request was made to the US FOIA (B) (6) to replace the fire extinguisher. The US FOIA (B) (6) complied with the request. The US FOIA (B) (6) confirmed the findings at the time of observation. The US FOIA (b)(6) and US FOIA (B) (6) were informed of the Life Safety Code deficiency during the survey exit on 06/25/2024 at approximately 12:20 PM. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING 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 REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 06/24/2024 and 06/25/2024, it was determined that the facility	K 374	1. No residents were affected by this deficient practice.	8/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 374	Continued From page 17 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 2 of 4 sets of corridor smoke barrier doors tested. this could effect all Residents who reside on the 2nd. floor and was evidenced by the following: Reference 1: Life Safety Code 101, 2012 Edition, - 8.5.4.1, Doors in smoke barriers shall close the opening, leaving only the minimum clearance necessary for proper operation, and shall be without louvers or grills. The clearance under the bottom of a new door shall be a maximum of 3/4 of an inch. On 06/24/2024 (day one of survey) during the survey entrance at approximately 9:06 AM, a request was made to the US FOIA (B) (6) and US FOIA (B) (6) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a two-story (2) building with 3 smoke zones with 25 Resident sleeping rooms on the first floor and 3 smoke zones with 26 Resident sleeping rooms on the second floor. Starting at approximately 9:15 AM on 06/24/2024 and continued on 06/25/2024, in the presence of the facility's US FOIA (B) (6), an inspection tour of the building was conducted. During the two (2) day tour of the facility the surveyor performed closure tests of the four (4) sets of double smoke doors in the corridors with the following results,	K 374	2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (B) (6) was educated on smoke barrier doors and checks for gaps when the doors are closed. Sweepers installed to cover gaps on the doors were identified. All fire doors checked to ensure no gaps when close. 4. Maintenance Director/designee will audit fire doors to ensure no gaps when closed weekly x 4 weeks and then monthly x2 months. Results of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 374	Continued From page 18 On 06/24/2024: 1) At approximately 10:41 AM, during a closure test of the double smoke doors on the second floor (next to Resident room #220), when the doors were release from the magnetic hold open device and allowed to self close into their frame. The surveyor observed, measure and recorded a 1-3/8 inch gap along the doors bottom edge. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. 2) At approximately 11:03 AM, during a closure test of the double smoke doors on the second floor (next to Resident room #206), when the doors were release from the magnetic hold open device and allowed to self close into their frame. The surveyor observed, measure and recorded a 1-1/8 inch gap along the doors bottom edge. This would allow the transfer of smoke, fire and poisonous gasses to pass from one smoke compartment to another in the event of a fire. The US FOIA (B) (6) confirmed the findings at the time of observation. The US FOIA (B) (6) were informed of the Life Safety Code deficiency during the survey exit on 06/25/2024 at approximately 12:20 PM. Life Safety Code 101, 2012 Edition. N.J.A.C. 8:39-31.1(c), 31.2(e)	K 374		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K 918		8/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 918	Continued From page 19 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 06/24/2024 and 06/25/2024 in the presence of the facility management, it was determined that the facility failed to	K 918	1. No residents were affected by this deficient practice. 2. All residents have potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 918	Continued From page 20 1) Install a remote manual stop station for 1 of 1 emergency generator 2) Exercise the one (1) emergency generator for at least 30 minutes in 20- to 40-day intervals, in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was identified and had the potential to affect 99 Residents who reside in the facility, and was evidenced by the following: The deficient practice was evidenced by the following: On 06/24/2024 (day one of survey) during the survey entrance at approximately 9:06 AM, a request was made to the US FOIA (B) (6) and US FOIA (B) (6) if the facility had an Emergency Generator, what type of fuel and how often does the facility run the emergency generator. The US FOIA (B) (6) told the surveyor, yes we have one (1) 125 KW (Kilowatt) Diesel Emergency Generator and we run it weekly and run it under load monthly. The surveyor asked the US FOIA (b)(6), "Do you document the load dates." The NJ Ex Order 28.4 told the surveyor , yes we keep a log. The surveyor requested emergency generator log for the last 12 months (June, July, August, September, October, November and December 2023, January, February, March, April and May 2024) for review later. Starting on 06/24/2024 at approximately 9:15 AM in the presence of the US FOIA (b)(6) a tour of the building was conducted. Along the tour at approximately 10:11 AM an inspection in the basement, where the Emergency Generator is located was performed.	K 918	3. US FOIA (B) (6) was educated on annual inspection for grounding, polarity, and blade tension for rooms with non-hospital grade outlets. 4. Maintenance Director/designee will audit all non-hospital grade outlets weekly x4 weeks and monthly x2 months to ensure all non-hospital grade outlets are inspected. Results of the audit will be reviewed during the monthly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. BUILDING **01** B. WING _____	**06/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	**56 HAMILTON AVENUE** **PASSAIC, NJ 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
K 918	Continued From page 21 The surveyor observed no evidence of remote Stop button for the 125 KW Diesel Emergency Generator. the surveyor observed no evidence of a remote stop for the generator. At this time the surveyor asked the US FOIA (b)(6), "Do you have a remote stop for the generator." The US FOIA (B) (6) told the surveyor, no. The surveyor observed the stop button was located on the generators control panel. On 06/25/2024 during a review of the facility provided generator monthly load tests, the surveyor reviewed the following monthly load dates; 6/30/2023, 7/28/2023, 8/31/2023, 9/29/2023, 10/30/2023, 11/30/2023, 12/29/2023, 2/29/2024, 3/29/2024 and 5/31/2024. On 06/25/2024 at approximately 10:14 the surveyor asked the US FOIA (B) (6) did the facility run the emergency generator under load for the months of January and April 2024. The US FOIA (B) (6) told the surveyor, no. There was no documented test for January and April 2024 monthly load test. The US FOIA (b)(6) confirmed the findings at the time of observation. The US FOIA (b)(6) were informed of the Life Safety Code deficiency during the survey exit on 06/25/2024 at approximately 12:20 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315221 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HAMILTON, LLC	56 HAMILTON AVENUE PASSAIC, NJ 07055

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0222	08/14/2024	LSC	K0271	08/14/2024	LSC	K0321	08/14/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0341	08/14/2024	LSC	K0351	08/14/2024	LSC	K0355	08/14/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0374	08/14/2024	LSC	K0918	08/14/2024	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO