STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315311	A. BUILDING _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PHILLIPSBURG, LLC	**843 WILBUR AVENUE PHILLIPSBURG, NJ 08865**

(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 000	INITIAL COMMENTS Complaint # NJ 174554, NJ 176529 Census 52 Sample size 5 The facility is substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		

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

Electronically Signed | 09/27/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062101	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PHILLIPSBURG, LLC	843 WILBUR AVENUE PHILLIPSBURG, NJ 08865

(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 The facility was not in compliance with the standards in the New Jersey Administrative Code, Chapter 8:39, Standards of Licensure of Long Term Care fcilities. The Facility must submit a Plan of Correction, including a completion date for each deficinecy and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement actions in accordance with the provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforecement 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: NJ174554, NJ 176529 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This was evident for 14 of 14-day shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	S 560	1. No residents were immediately affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. The Director of Nursing / Designee inserviced Staffing Coordinator on appropriate staffing levels. Additional per diem, part-time and full-time staff were scheduled to meet minimum staff to resident ratios. The facility has advertised open jobs through online recruitment platforms. The facility has conducted job fairs and has partnered with local schools for newly licensed or certified staff.	9/27/24

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

Electronically Signed | 09/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062101	A. BUILDING: _____ B. WING _____	C 09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PHILLIPSBURG, LLC	843 WILBUR AVENUE PHILLIPSBURG, NJ 08865

(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 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: The facility was deficient in CNA staffing for residents on 5 of 14 day shifts and deficient in total staff for residents on 9 of 14 overnight shifts as follows: -08/26/24 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. -08/27/24 had 3.25 total staff for 53 residents on the overnight shift, required at least 4 total staff. -08/28/24 had 3 total staff for 53 residents on the overnight shift, required at least 4 total staff. -08/29/24 had 3.3 total staff for 54 residents on the overnight shift, required at least 4 total staff. -08/30/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -08/30/24 had 3.55 total staff for 54 residents on the overnight shift, required at least 4 total staff. -08/31/24 had 3.55 total staff for 54 residents on the overnight shift, required at least 4 total staff. -09/01/24 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -09/02/24 had 3.8 total staff for 53 residents on the overnight shift, required at least 4 total staff. -09/04/24 had 3.7 total staff for 51 residents on the overnight shift, required at least 4 total staff. -09/05/24 had 3.8 total staff for 51 residents on the overnight shift, required at least 4 total staff. -09/06/24 had 5.5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -09/06/24 had 3.8 total staff for 51 residents on the overnight shift, required at least 4 total staff. -09/07/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs.	S 560	4. The Director of Nursing or designee will audit staffing levels three times a week for 3 months. All findings will be reported and reviewed by the QAPI committee monthly.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
062101 Y1	A. Building B. Wing Y2	9/30/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PHILLIPSBURG, LLC	843 WILBUR AVENUE PHILLIPSBURG, NJ 08865

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 09/27/2024	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 9/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			