

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2023
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT PHILLIPSBURG, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 843 WILBUR AVENUE PHILLIPSBURG, NJ 08865		
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F 000	INITIAL COMMENTS Standard Survey: 1/9/23 Census: 52 Sample Size: 15 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		2/8/23	

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

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Electronically Signed

02/01/2023

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.

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F 761	<p>Continued From page 1 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to date medication when opened and stored for continued use. This was found in 2 of 3 medication carts and 1 of 1 medication refrigerator.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 12/20/22 at 9:35 AM, the surveyor inspected the annex medication cart with Licensed Practical Nurse #1 (LPN #1). Inside of the annex medication cart there was one vial of Humalog insulin that was open and dated 9/13/22 and one vial of Humalog insulin that was open and dated 9/20. LPN # 1 confirmed the dates then took them and said they were out dated and he didn't know why they were in the medication cart. According to manufacturer specifications Humalog insulin should be discarded 28 days after opening.</p> <p>On 12/20/22 at 9:55 AM, the surveyor inspected the medication refrigerator with the [REDACTED] (U.S. FOIA (b)(6)). Inside of the medication refrigerator there was a vial of Influenza vaccine that was open and undated. The [REDACTED] (U.S. FOIA (b)(6)) confirmed that there was no date and there should have been. According to the manufacturer specifications the vial should be discarded 28 days after opening.</p> <p>On 12/20/22 at 10:16 AM, the surveyor inspected the west hall medication cart with LPN #2. Inside of the west hall medication cart there was a</p>	F 761	<ol style="list-style-type: none"> All expired and undated medications were disposed of appropriately. All residents can be affected by this deficient practice. All other medications in the facility were inspected to ensure there were no expired or undated medications. Licensed nursing staff will be re-educated on proper storage of medication. An audit will be completed by the DON or his/her designee one time per week for six weeks of medication storage areas to ensure proper storage of medication and medications are not expired. All findings will be reported and reviewed by the QAPI committee monthly. Compliance date is 2/8/2023. 		

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F 761	<p>Continued From page 2</p> <p>Levalbuterol Inhalation Solution package of vials that was open and undated. According to manufacturer instructions once opened the vials must be used within 2 weeks. LPN #2 confirmed that the package should have been dated when it was opened.</p> <p>On 12/20/22 at 1:30 PM, the survey team spoke with the U.S. FOIA (b)(6) () and made them aware of the concerns with the undated or expired medication found in the medication carts and refrigerator. The U.S. FOIA (b) confirmed that the vials and package should have been dated when opened and the expired vials of insulin should have been discarded.</p> <p>On 12/21/22 at 1:18 PM, the surveyor reviewed the facility's policy and procedure titled "Labeling of Medication Containers." Under "Policy Statement" it read "All medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations," and reviewed the policy and procedure titled "Administering Medications" dated 9/2022. Under Policy it read "The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container."</p>	F 761			
F 812 SS=D	<p>NJAC 8:39-29.4 (h)</p> <p>Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)</p> <p>§483.60(i) Food safety requirements. The facility must -</p> <p>§483.60(i)(1) - Procure food from sources</p>	F 812		2/8/23	

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F 812	<p>Continued From page 3</p> <p>approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and policy review it was determined that the facility failed to a.) store potentially hazardous foods in a manner to prevent food borne illness, b.) failed to maintain the kitchen environment and equipment in a sanitary manner to prevent contamination from foreign substances and potential for the development of a food borne illness.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 12/19/22 at 9:15 AM, in the presence of the U.S. FOIA (b)(6) and the U.S. FOIA (b)(6), the surveyor observed the following:</p> <ol style="list-style-type: none"> In the food preparation area, the surveyor observed grey colored material stuck on the blade of the can opener. On a shelf in the Cook's refrigerator, the 	F 812	<ol style="list-style-type: none"> The gray colored material on the can opener was removed and cleaned. The expired cranberry sauce was discarded. The black grease like substance on the stove top burners was removed and cleaned. The gray dust like particles were removed from the sprinklers. All residents in the facility can be affected by these deficient practices. All other areas in the kitchen were inspected to ensure a clean and sanitary environment. Dietary staff will be re-educated on the proper manner to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Dietary staff will be re-educated on proper cleaning of the dietary equipment and sprinkler heads. 		

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F 812	<p>Continued From page 4</p> <p>surveyor observed a container of cranberry sauce, which had a written date in marker of 11/16/21 and a stamped manufacturer expiration date of 7/23/22. The [REDACTED] stated he was not sure what the written date on the item or the manufacturer's date on the item was indicating, and disposed of the cranberry sauce.</p> <p>3. The surveyor observed four of six stovetop burners were soiled with a black grease-like substance. [REDACTED] stated the stove was cleaned once a week.</p> <p>4. Above the stove top, the surveyor observed the overhead sprinklers which were soiled with grey dust-like particles.</p> <p>On 12/19/22 at 10:42 AM, the surveyor informed the [REDACTED] U.S. FOIA (b)(6) of the above concerns.</p> <p>The surveyor reviewed the facility's policy titled, "Equipment" with a revised date of September 2022. The policy read "All foodservice equipment will be clean, sanitary, and in proper working order". Under Procedures, it read "3. All food contact equipment will be clean and free of debris".</p> <p>The surveyor reviewed the facility's policy titled, "Environment" with a revised date of September 2022. The policy indicated that all food preparation areas, food service areas will be maintained in a clean and sanitary condition.</p> <p>The surveyor reviewed the facility's policy titled, "Food Storage: Cold Foods" with a revised date of September 2022. The policy indicated that all</p>	F 812	<p>4. An audit will be completed by the food service director or his/her designee daily for two weeks, then weekly x4 weeks. The audits will consist of proper food storage, and proper cleaning practices. All findings will be reported and reviewed by the QAPI committee monthly. Compliance date is 2/8/2023</p>		

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F 812	Continued From page 5 foods should be labeled and dated. The policy did not further address checking food item expiration dates.	F 812			
F 880 SS=D	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		1/31/23	

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F 880	<p>Continued From page 6</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to clean and disinfect three of three shower chairs observed in the shower room. This deficient</p>	F 880	<p>1. The black colored substance on each of the shower chairs was immediately removed.</p> <p>2. All residents can be affected by these</p>		

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F 880	<p>Continued From page 7</p> <p>practice was as evidenced by the following:</p> <p>On 12/22/22 at 10:40 AM, the surveyor interviewed five residents during a resident council meeting. At the end of the resident council meeting, the surveyor asked the residents if they had any other concerns and two of five residents stated that the shower chairs in the shower room were not clean and that the shower chairs had black and brown substances on them.</p> <p>On 12/22/22 at 12:15 PM, the surveyor went into the shower room and observed three shower chairs stored inside the room. The surveyor observed one shower chair's four metal legs were each soiled with a black colored substance and the plastic seating bench of the chair had a brown colored substance in the holes of the bench and a brown colored substance on the entire under side of the bench. The surveyor observed two of two white Polyvinyl chloride (PVC) plastic shower chairs with mesh seat backings in the shower room as well. Each of the four legs on the two PVC plastic shower chairs were soiled with a black colored substance and the mesh seat backings were both soiled with a black colored substance as well.</p> <p>At 12:18 PM, the surveyor asked the [U.S. FOIA (b)(6)] to come to the shower room and to observe the three shower chairs. The [U.S. FOIA (b)(6)] stated that the three chairs were soiled and should not be like this. The [U.S. FOIA (b)(6)] stated that the chairs need to be cleaned.</p> <p>At 12:32 PM, in the presence of the [U.S. FOIA (b)(6)], the surveyor interviewed the [U.S. FOIA (b)(6)] who stated that the chairs had never been cleaned by the housekeeping department and it</p>	F 880	<p>deficient practices. All other areas of the shower room were inspected to ensure a clean and sanitary environment.</p> <p>3. Housekeeping and nursing staff will be re-educated on the proper cleaning of shower chairs, including the shower chair cleaning schedules.</p> <p>An audit will be completed by the DON or his/her designee one time per week for eight weeks to ensure cleanliness of the shower chairs. All findings will be reported and reviewed by the QAPI committee monthly.</p> <p>A DPOC was imposed upon the facility and an RCA was completed. In-service videos and modules were viewed by staff as follows:</p> <p>Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350 All topline staff completed this training. CDC COVID-19 - Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw All frontline staff completed this training. CDC COVID-19 Sparkling Surfaces https://youtu.be/t7OH8ORr5IG All frontline staff completed this training. CDC COVID-19 Clean Hands https://youtu.be/xmYMUly7qiE All frontline staff completed this training. Module 5 Outbreaks https://www.train.org/cdctrain/course/1081803/ All topline staff completed this training. Module 11B Environmental Cleaning and Disinfection https://www.train.org/main/course/1081815/ All staff completed this training.</p>		

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F 880	Continued From page 8 was never on their cleaning schedule to do so. The [REDACTED] stated that the nursing staff were also not cleaning the shower chairs. The surveyor reviewed the Cleaning and Disinfecting Critical and Non-Critical Resident Equipment policy, dated 6/2022, which revealed that non-critical and reusable resident care equipment will be decontaminated and/or sterilized between residents. N.J.A.C. 8:39-19.4(a)	F 880	Module 7 Hand Hygiene https://www.train.org/main/course/1081806/ All staff completed this training. Module 6A Principles of Standard Precautions https://www.train.org/main/course/1081804/ All staff completed this training. Module 6B Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ All staff completed this training. Module 11A Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/1081814/ All topline staff completed this training. The compliance date for the facility is 2/8/2023. Why: Upon interview of the Housekeeping Director, there was a shower room cleaning schedule, however, due to a breakdown of communication between the Director and her staff, the cleaning of the of the chairs were not being done.		

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S 000	Initial Comments] THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	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: 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. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the	S 560	1. No residents were immediately affected by this deficiency. 2. All residents have the potential to be affected by this deficiency. 3. The Director of Nursing or designee will review the CNA daily staffing sheets on a daily basis for eight weeks to ensure the staffing requirements are met. The facility	2/1/23

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

TITLE

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Electronically Signed

02/01/23

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S 560	<p>Continued From page 1</p> <p>Revised Statutes.</p> <p>Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.</p> <p>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:</p> <p>(1) one certified nurse aide to every eight residents for the day shift;</p> <p>(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</p> <p>(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</p> <p>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.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth</p>	S 560	<p>has advertised open jobs on online recruitment platforms as well as traditional recruitment firms. There is also a signed contract with a staffing agency.</p> <p>4. The Director of Nursing or designee will audit staffing levels three times a week for eight weeks. All findings will be reported and reviewed by the QAPI committee monthly.</p>	

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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
S 560	<p>Continued From page 2</p> <p>place.</p> <p>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>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 ...</p> <p>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 12/04/2022 to 12/10/2022 and 12/11/2022 to 12/17/2022 for the 12/2022 standard survey revealed the following.</p> <p>The facility was deficient in CNA staffing for residents on 6 of 14 day shifts and on 4 of 14 overnight shifts as follows:</p> <ul style="list-style-type: none"> -12/05/22 had 5 CNAs for 51 residents on the day shift; required 6 CNAs. -12/06/22 had 5 CNAs for 51 residents on the day shift; required 6 CNAs. -12/06/22 had 3 total staff for 51 residents 	S 560		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062101	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2023
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT PHILLIPSBURG, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 843 WILBUR AVENUE PHILLIPSBURG, NJ 08865		
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S 560	Continued From page 3 on the overnight shift; required 4 total staff. -12/10/22 had 4.5 CNAs for 51 residents on the day shift; required 6 CNAs. -12/10/22 had 3 total staff for 51 residents on the overnight shift; required 4 total staff. -12/11/22 had 3 total staff for 51 residents on the overnight shift; required 4 total staff. -12/12/22 had 5 CNAs for 51 residents on the day shift; required 6 CNAs. -12/13/22 had 5 CNAs for 52 residents on the day shift; required 6 CNAs. -12/16/22 had 3 total staff for 52 residents on the overnight shift; required 4 total staff. -12/17/22 had 4.5 CNAs for 52 residents on the day shift; required 6 CNAs. On 12/28/22 at 12:15 p.m., the surveyor informed the Director of Nursing and the Licensed Nursing Home Administrator of the shifts when the minimum direct care staff to resident ratio was not met.	S 560		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315311	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/24/2023	Y2	Y3
NAME OF FACILITY COMPLETE CARE AT PHILLIPSBURG, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 843 WILBUR AVENUE PHILLIPSBURG, NJ 08865		

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 F0761	Correction	ID Prefix F0812	Correction	ID Prefix F0880	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	02/08/2023	LSC	02/08/2023	LSC	01/31/2023
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	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/9/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 062101	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/24/2023	Y3
NAME OF FACILITY COMPLETE CARE AT PHILLIPSBURG, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	02/01/2023	LSC _____		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 _____	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/9/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

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

PRINTED: 03/14/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2023
NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT PHILLIPSBURG, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 12/08/2022. The facility was found to be in compliance with 42 CFR 483.73.	E 000			
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 01/09/2023 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 Complete Care @ Phillipsburg is a 1 story - building with a partial basement that was built in 1989. It is composed of Type II protected construction. The facility is connected onto the original three - story building with a two - hour separation. The facility is divided into two- smoke zones. The generator does approximately 100% of the building as per the Documentation provided. The current occupied beds are 53 of 60.	K 000			
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges,	K 211		2/1/23	

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

TITLE

(X6) DATE

Electronically Signed

02/01/2023

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: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2023
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K 211	<p>Continued From page 1</p> <p>exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>.</p> <p>Based on observation and interview, the facility failed to ensure that the fire doors were inspected annually in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 157 residents.</p> <p>Findings include:</p> <p>On 01/09/2023 from 8:45 AM to 10:00 AM, a document review revealed that the fire door inspections were not conducted. Observation from 10:10 AM to 12:00 PM confirmed that no inspections were conducted on any of the facilities' fire doors and the doors lacked the required inspection tags that shall be placed on the door after the inspection.</p> <p>The U.S. FOIA (b)(6) was present at the time of observation and confirmed the doors were not inspected.</p> <p>NJAC 8:39-31.1(c)</p> <p>.</p>	K 211	<ol style="list-style-type: none"> 1. It is the policy of the facility to assure that all residents, staff, and visitors are free from any potential hazards. It is our responsibility to ensure that the facility is compliant with all Life Safety Regulations. 2. All residents have the potential of being affected by this deficient practice. 3. An inspection of all fire doors was conducted by a contracted company, NJ Ex Order 26.4(b)(1), on 2/1/2023 to ensure compliance. The next inspection is due by 1/31/2024. 4. The maintenance supervisor/ designee will ensure this is done without delay when due. <p>Maintenance Auditing Systems and its corresponding Inspections were discussed at our monthly QAPI meeting by the interdisciplinary team. The Maintenance Director /Designee will ensure that this is completed by the due date. This will be documented in TELS, the facility's online building maintenance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/09/2023
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K 211	Continued From page 2	K 211	tasks management tool to ensure compliance. TELS sends a weekly scorecard of completed as well as due regulatory and required building maintenance tasks to the Maintenance Director and the Administrator.		
K 291 SS=F	<p>Emergency Lighting CFR(s): NFPA 101</p> <p>Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview, the facility failed to ensure emergency lighting was provided at the emergency generator transfer switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 edition) section 7.3. This deficient practice had the potential to affect all 53 residents.</p> <p>Findings include:</p> <p>Observation on 01/09/23 at 11:42 AM revealed emergency lighting was not present at the emergency generator transfer switch located in the basement.</p> <p>The U.S. FOIA (b)(6) who was present at the time of the observation confirmed the emergency lighting was not present.</p> <p>The former U.S. FOIA (b)(6) arrived at the facility at approximately 1:30 PM on 01/09/23 and stated the emergency light was present with the</p>	K 291	<p>1. It is the policy of the facility to assure that all residents, staff, and visitors are free from any potential hazards. It is our responsibility to ensure that the facility is compliant with all Life Safety Regulations.</p> <p>2. All residents have the potential of being affected by this deficient practice.</p> <p>3. Emergency lighting was provided at the emergency generator transfer switch. The installation of the emergency light was completed by the Maintenance Director. The facility was compliant on 2/8/2023.</p> <p>4. The maintenance supervisor/ designee will ensure that the light at the emergency light at the generator transfer switch is always functional.</p>	2/8/23	

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K 291	Continued From page 3 old transfer switch but, was removed when the new transfer switch was installed, and was not reinstalled. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	Maintenance Auditing Systems and its corresponding Inspections were discussed at our monthly QAPI meeting by the interdisciplinary team to ensure that the light at the emergency switch is always functional. The Maintenance Director/Designee will conduct weekly inspections to ensure that the light functions properly and document in TELS, our building maintenance online tasks management system.		
K 918 SS=F	Electrical Systems - Essential Electric System CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing 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	K 918		1/26/23	

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K 918	<p>Continued From page 4</p> <p>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.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>-</p> <p>Based on document review and interview, the facility failed to ensure the three - year load bank test was completed on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 edition) section 4.9.1 This deficient practice had the potential to affect all 53 residents.</p> <p>Findings include:</p> <p>Document review of the generator reports for 2021 and 2022 provided by the U.S. FOIA (b)(6) on 01/09/23 at 9:15 AM revealed a three - year load bank test had not been completed for the emergency generator.</p> <p>During an interview with the U.S. FOIA (b)(6) and the former U.S. FOIA (b)(6) at approximately 1:30 PM on 01/09/23 confirmed that the 3 - load bank test had not been completed on the emergency generator.</p> <p>NJAC 8:39-31.2(e) NFPA 99, 110</p> <p>.</p>	K 918	<p>1. It is the policy of the facility to assure that all residents, staff, and visitors are free from any potential hazards. It is our responsibility to ensure that the facility is compliant with all Life Safety Regulations.</p> <p>2. All residents have the potential to be affected by this deficient practice.</p> <p>3. A load bank test of the generator was immediately scheduled with <small>NJ Ex Order 26.4(b)(1)</small>. The load bank test was performed and completed on 1/26/2023. Next scheduled test will be 1/25/2026.</p> <p>4. The maintenance supervisor will ensure this is done without delay in the next 36 months from the current completion date of 1/26/2023.</p> <p>Maintenance Auditing Systems and its corresponding Inspections were discussed at our monthly QAPI meeting by the interdisciplinary team and the maintenance Director will ensure that the next due load bank testing will be done by</p>		

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NAME OF PROVIDER OR SUPPLIER COMPLETE CARE AT PHILLIPSBURG, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 843 WILBUR AVENUE PHILLIPSBURG, NJ 08865		
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K 918	Continued From page 5	K 918	1/25/2026 and this has been documented in "Direct Supply TELS", our budling maintenance online tasks Managment tool. This will serve as a reminder to the maintenance Director to have the testing done by the due date.		

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315311	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 2/24/2023	Y3
NAME OF FACILITY COMPLETE CARE AT PHILLIPSBURG, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 843 WILBUR AVENUE PHILLIPSBURG, NJ 08865		

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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 K0211	02/01/2023	LSC K0291	02/08/2023	LSC K0918	01/26/2023
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 _____	
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 <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/9/2023		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		