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COMPLETE CARE AT PHILLIPSBURG, LLC	**843 WILBUR AVENUE PHILLIPSBURG, NJ 08865**

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F 000	INITIAL COMMENTS A Federal Comparative Survey was conducted by the Centers for Medicare and Medicaid Services (CMS) at the Complete Care at Phillipsburg for the purpose of federal oversight, monitoring, and to determine the facility's compliance with 42 Code of federal Regulations (CFR) Part 483 requirements for Long Term Care The facility was found to not be in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Survey Date: 02/27/2023 - 03/03/2023 Census: 54 Sample Size: 17 plus 2 closed records + 24 = 43	F 000		
F 577 SS=D	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding	F 577		

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

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

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F 577	Continued From page 1 years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed: to have Department of Health Recertification surveys reports for the three preceding years and any plan of correction in effect with respect to the facility, available for any individual to review upon request. This deficient practice was evidenced by the following: - During the resident council meeting, Resident # 99 verbalized that, he/she was unable to find the Department of Health (DOH) inspection report in the binder at the reception area. - On 02/28/23 the DOH Inspection report binder was reviewed by two federal surveyors, revealed that the binder didn't have the last three preceding years reports in it. - 02/28/23 around 01:27 PM the Facility Acting Administrator (AA) and the Regional Clinical Specialist (RCS) were interviewed, both acknowledged the concern. - CA stated, he only saw the 2019 survey report in the binder. - RCS stated he didn't see last three preceding years reports in the binder and will update the binder.	F 577		

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F 583	Continued From page 2	F 583		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		

§483.10(h) Privacy and Confidentiality.
The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

§483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.
(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.
(ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record

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review, it was determined that the facility failed to ensure resident was treated with respect, dignity in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each Resident's individuality to protect and promote the rights of the Resident. Specifically, the facility failed to ensure that residents NJ EX Order: 264b1 was stored in a dignified manner for one resident (Resident #149).

This deficient practice was evidenced by the following:

On 02/27/23 at approximately 11:51 AM, the surveyor observed resident #149 in bed during the initial pool process. The Resident's bed was at the door side of the room, and a NJ EX Order: 264b1, which was dated NJ EX Order: 264b1 was attached to the right side of the resident's bed frame, and was visible from the door. The NJ EX Order: 264b1 contained approximately NJ EX Order: 264b1.

Resident #149 was re-admitted to the facility after hospitalization on NJ EX Order: 264b1 with a diagnosis NJ EX Order: 264b1.

On 02/28/23, 11:59 AM - Record Review - Physician order: NJ EX Order: 264b1 NJ EX Order: 264b1 with NJ EX Order: 264b1 NJ EX Order: 264b1 to bedside NJ EX Order: 264b1 for NJ EX Order: 264b1 one time a day every NJ EX Order: 264b1 month(s) starting on the NJ EX Order: 264b1 day(s) NJ EX Order: 264b1.

On 03/01/23 around 10:32 AM, the Unit Manager (UM) was interviewed who stated, the NJ EX Order: 264b1 should be in a NJ EX Order: 264b1

On 03/28/23 approximately around 10:52 AM, CNA # 6 (Certified Nursing Assisstant) was

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F 583	Continued From page 4 interviewed who stated, the CNAs change the NJ EX Order: 26.4b1 once a week and he/she did not recall if the resident # 149 had NJ EX Order: 26.4b1 NJ EX this week. On 03/28/23 approximately 11:00 AM the Infection Preventionist (IP) was interviewed who stated, the day shift staff were supposed to change the NJ EX Order: 26.4b1 NJ EX once a week. Policy Titled Quality of Life - Dignity which was dated "2001-Med-Pass, Inc. (Revised August 2009), Adopted 11/2018 Updated 10/2019" was reviewed and revealed the following: - Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. - Demeaning practices and standards of care that compromise dignity are prohibited Staff shall promote dignity and assist residents as needed by: Helping the resident to keep urinary catheter bags covered.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		

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receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined that the facility failed to maintain a clean, orderly, functional, and sanitary environment for the residents. This deficient practice was identified for multiple resident rooms inspected.

This deficient practice was evidenced by the following:

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1.) On 02/27/2023 at 01:28 PM, the surveyor conducted an environmental tour of residents' rooms and observed the following:

1. Room [redacted] - room: walls have chipped paint with exposed drywall; bathroom: sink was dripping water (water in off position)
2. Room [redacted]- room: walls (no paint) exposed drywall; bathroom: damaged floor tiles and baseboards and water leaking from sink hot water handle.
3. Room [redacted] bathroom: wallpaper peeling with exposed drywall.
4. Room[redacted] - room: walls have chipped paint with exposed drywall
5. Room [redacted]- room: walls have exposed drywall; bathroom: wood paneling around sink in disrepair with exposed sharp edges
6. Room [redacted]- room: multiple floor tiles rising, cracked, and missing pieces.
7. Room [redacted] - room: hole in wall next to bathroom near baseboard trim with drywall debris; bathroom: sink leaking water with left and right handles loose. Walls have exposed spackle in multiple areas.
8. Room [redacted] - room: multiple floor tiles rising, cracked, and peeling

On 03/01/23 at 02:06 PM, CNA#7 was Interviewed, she was assigned to rooms [redacted], [redacted], and [redacted] She admitted, she was aware of the hole in the wall in room [redacted] and other environmental issues in the other rooms. Specifically, she indicated the hole in the wall, in room [redacted] has been there for a couple of months. She indicated her unit manager was made aware.

On 03/01/23 at 02:43 PM, LPN#1 was interviewed. She admitted, she was aware of the issues in the residents' rooms and reported the

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bathroom issues in room [redacted] around 4 months ago in TELS (building management platform) and made the UM aware.

On 03/01/23 at 02:47 PM, UM was interviewed, she was aware of the multiple rooms in disrepair. Maintenance was notified and aware of the issues.

On 03/01/23 at 03:00 PM, the maintenance director (FMD) and AA were interviewed. The FMD admitted, he is aware of the multiple issues in the resident's rooms. He indicated specifically room [redacted] was in the middle of a remodel before the previous FMD left. He indicated he patched up the bathroom holes. He indicated not aware of any remodels. The AA admitted, he was aware of the physical plant in disrepair - cosmetically. He indicated that he will have another staff member come from a sister facility to help fix and paint facility.

2.) On 02/27/23 at 12:58 PM, the surveyor observed the following in resident room #14: Heavy dust accumulation on the wall-to-floor junction in the bathroom and under the sink area. The faucet was leaking. The baseboard in the bathroom was in disrepair. The caulking around the sink area was peeling off. There was a visible sign of water damage on the wall under the sink. The vinyl floor under the sink had heavy brown dried unknown substance and stains.

On 02/27/23 at approximately 1:10 PM, the surveyor observed the following in resident room #16: The faucet was leaking. The baseboard in the bathroom was in disrepair. The caulking around the sink area was peeling off and had a black stain. There was a visible sign of water damage on the wall under the sink. The vinyl floor

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F 584	Continued From page 8 under the sink had heavy brown dried unknown substance and stains.	F 584		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to adhere to acceptable standards of quality and clinical practice and meet the professional standards of care. Specifically, the Licensed Practical Nurses (LPN) were conducting and documenting initial nursing comprehensive admission assessments without Registered Nurse (RN) concurrence 2 of 2 residents (9, 99). This deficient practice was evidenced by the following: Resident # 9's medical record review revealed the following : - Resident # 9 was admitted to the facility on [redacted]. - On [redacted] at 10:03 PM, resident#9's Nursing Comprehensive Assessment - ADMIT/READMIT/ANNUAL/SIG CHANGE was completed and signed by LPN#3. - On [redacted] at 06:43 AM, resident #9's Nursing Skilled Documentation (nursing assessment) was	F 658		

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F 658	Continued From page 9 signed by LPN#4. - On [redacted] at 02:49 PM, the Nursing Skilled Documentation was signed by LPN#5. - On [redacted] at 11:01 PM, resident #9's Nursing Skilled Documentation was signed by by LPN#3. - A review of the progress notes revealed, LPN#3 completed a readmission note on [redacted] at 7:29 CT. Resident #99 medical record review revealed the following: - Resident # 99 was admitted to the facility on [redacted] - On [redacted] at 6:34 PM, the Nursing Comprehensive Assessment - ADMIT/READMIT/ANNUAL/SIG CHANGE was completed and signed by LPN #6. - The Nursing Skilled Documentation (nursing assessment) dated 12/20/23 at 6:34 PM and signed on [redacted] by LPN#6. - Nursing Skilled Documentation dated [redacted] at 2:34 AM and signed on [redacted] by LPN#7. - On [redacted] at 9:34 AM, the Nursing Skilled Documentation dated and signed by LPN#2. On 03/01/23 approximately at 12:20 PM, the Unit Manager, a Licensed Practical Nurse,(UM) was interviewed. She stated, the LPNs finishes the residents admission assessments. UM further stated that, she review the assessments with the RN the following day after the assessment	F 658		

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completion by the LPNs.

On 3/3/23 at 10:35 AM, the Administrator and the Facility Director of Nursing (DON) were interviewed. The AA confirmed that the LPNs complete the residents admission assessments and the UM does the verification.

On 3/3/23 at 10:50 AM, the AA and the DON reviewed the medical record with the surveyor for further clarification. During the medical record review the DON and the AA were interviewed. During the interview the AA stated, LPNs were not allowed to do resident assessments but they can do evaluations. The AA further stated, the RNs review the evaluation and co-sign the evaluations. The facility DON reviewed resident # 9's medical record with the surveyor, for the RN concurrence of the Nursing Comprehensive Assessment - ADMIT/READMIT/ANNUAL/SIG CHANGE. After reviewing the medical record of resident #9, the facility DON and the AA confirmed that, resident's admission assessment which was completed by LPN#3 had no RN concurrence.

On 03/03/2023 around 10:59 AM, after reviewing resident #99's medical record with the surveyor, the DON and the AA acknowledged that, the Nursing Comprehensive Assessment - ADMIT/READMIT/ANNUAL/SIG CHANGE which was completed by LPN #6 had no RN concurrence.

A review of the facility policy dated 1/2019 titled, "Admission Notes" indicated the following under Policy Interpretation and Implementation.

- t. The signature and title of the person recording

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F 658	Continued From page 11 the data. The assessment must be completed by an RN or an evaluation can be done by an LPN with an RN co-signature and/or concurrence within 24 hours.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the medical record, it was determined that the facility failed to ensure that necessary care, including NJ EX Order. 264b1 and NJ EX O care, was provided to residents that were dependent on the staff assistance for hygiene for two residents reviewed, Resident #34 and Resident #37. This deficient practice was evidenced by the following: On 02/27/23 at 12:00 PM, the surveyor observed Resident #34 in the dining room, sitting in a wheelchair with both eyes open. The surveyor further observed the resident's NJ EX Order. 264b1 on NJ EX Or NJ EX O s were NJ EX Order. 264b1, and had dirt accumulation under NJ EX Order. 264b1. NJ EX Order. 264b1 was also noted. The same was observed on NJ EX Order. 264b1 at approximately 12:05 PM. The resident was unable to respond to simple direct questions when interviewed. On 03/02/23 at 09:40 AM, the surveyor observed the resident in their room, sitting in a wheelchair with both eyes open. The resident smiled when	F 677		

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asked simple direct questions and could not answer verbally. It was further observed that the resident had NJ EX Order. 264b1 and remained with NJ EX Order. 264b1 with NJ EX Order. 264b1.

Certified Nursing Assistant (CNA) #1 was interviewed and confirmed the findings at that time. CNA#1 stated that she had the resident in her assignment. CNA#1 confirmed that the resident had NJ EX Order. 264b1 and required assistance with care, including NJ EX Order. 264b1 care, due to the resident's NJ EX Order. 264b1. CNA #1 could not provide information on when the last time she NJ EX Order. 26 and provided NJ EX Order. 264 to the resident was but added that she would do it today.

The surveyor reviewed the Admission Record of Resident #34, which reflected that the resident was admitted on NJ EX Order. 264b1 with NJ EX Order. 264b1

According to the Minimum Data Set, an assessment tool dated NJ EX Order. 264b1, the resident was NJ EX Order. 264b1 and required NJ EX Or staff assistance for personal hygiene.

A review of Resident #34's Care Plan (CP) revealed that the resident required assistance and was dependent on Activities of Daily Living (ADL) care, including bathing, grooming, and personal hygiene ... due to NJ EX Order. 264b1. The CP further revealed a goal that the resident's ADL care needs will be anticipated and met throughout the next review period with a revision date of NJ EX Order. 264b1.

On 02/27/23 at 01:00 PM, the surveyor observed Resident #37 in their room, sitting in bed and

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COMPLETE CARE AT PHILLIPSBURG, LLC	**843 WILBUR AVENUE PHILLIPSBURG, NJ 08865**

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F 677	Continued From page 13 eating lunch. The surveyor further observed the resident was wearing a hospital gown and noted that the resident's NJ EX Order: 264b1 were NJ EX Order: 264b1 , and had NJ EX the NJ EX Order: 264b1 . The surveyor also noted that the resident's NJ EX Order: 264b1 were unkempt On 03/02/23 at 10:03 AM, the surveyor observed Resident #37 in their room sitting in a wheelchair, remained with NJ EX Order: 264b1 and NJ EX Order: 264b1 NJ EX When interviewed, the resident was unable to provide information on when the last time they were NJ EX Order: 26 and received NJ EX Or care. At that time, CNA#1 was interviewed and confirmed the findings. CNA#1 stated that she had the resident in her assignment. CNA#1 confirmed that the resident had NJ EX Order: 264b1 , with some episodes of NJ EX Order: 264b1 and required assistance with care, including NJ EX Order: 264b1 care, due to the resident's NJ EX Order: 264b1 status. CNA#1 could not provide information on when the last time she NJ EX Order: 26 and provided NJ EX Or care to the resident was but added that she would do it today. The surveyor reviewed the Admission Record of Resident #37, which reflected that the resident was admitted on NJ EX Order: 264b1 with diagnoses that included but were not limited to: NJ EX Order: 264b1 . According to the MDS dated NJ EX Order: 264b1 , the resident required NJ EX Order: 264b1 staff assistance for personal hygiene. A review of Resident #37's Care Plan (CP) revealed that the resident required NJ EX Order: 264b1 assistance ADL care in bathing, grooming, and personal hygiene ... due to the chronic condition of NJ EX Order: 264b1	F 677		

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F 677	Continued From page 14 On 03/02/23 at 10:41 AM, during an interview with the Director of Nursing (DON) and the Unit Manager (UM), the DON stated that the expectation was for the CNAs to provide the necessary assistance to residents dependent and requiring assistance with daily care, including NJ EX Order: 26 and NJ EX l care. The UM confirmed that NJ EX Order: 2 and NJ EX O care were part of morning care to provide and maintain dignity for the residents.	F 677		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure proper signage was posted when NJ EX Order: 26 was in use 1 of 4 residents (#20) This deficient practice was evidenced by the following: On 3/1/23 at 01:58 PM, the surveyor observed an NJ EX Order: 264b1 turned on and in use in resident room NJ EX Order: 2 without proper signage NJ EX Order: 264b1 The medical record revealed the following:	F 695		

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F 695	Continued From page 15 A review of the Face Sheet (admission summary), reflected that the resident was admitted to the facility on NJ EX Order. 264b1 with diagnoses that included NJ EX Order. 264b1 NJ EX O NJ EX Order. 264b A review of the Physician's Order Sheet (POS) dated NJ EX Order. 264b1 indicated an active order for NJ EX Order. 264b1 per NJ EX Order. 264b1 dated NJ EX Order. 2 On 3/1/23 at 02:09 PM, the CNA#4 was interviewed. She admitted, she received report and round on all residents assigned at the beginning and throughout the shift. She indicated, she did not realize there was no NJ EX Order. 26 in use signage for resident room NJ EX Order. 2 On 3/1/23 at 02:14 PM, the LPN#2 was interviewed. He admitted, no NJ EX Order. 26 in use sign was posted for resident bed NJ EX Order. 264b1 stated that the Infection Preventionist and nursing are responsible to assure signage was posted. On 3/1/23 at 02:16 PM, the UM was interviewed. She admitted there was no signage and took full responsibility. On 3/3/23 at 10:00 AM, the DON was interviewed. She admitted nursing staff was responsible for ensuring NJ EX Order. 264b1 per doctor's orders and signage. A review of the policy dated 10/2019 titled, "NJ EX Order. 264 Administration" revealed the following under Steps in the Procedure.	F 695		

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F 695	Continued From page 16 A. Place an [redacted] in Use" sign on the outside of the room entrance door. Close the door. B. Place an [redacted] in Use" sign in a designated place on or over the resident's bed.	F 695		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755		

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is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined that the facility failed to consistently maintain an accounting of controlled substances stored in the facility's automated medication dispensing system (AMDS).

This deficient practice was evidenced by the following:

On 02/28/23 at approximately 01:30 PM, the Unit Manager (UM) informed the surveyor that the facility utilized an AMDS for controlled and emergency medications for all residents. At that time, the UM stated that the facility routinely performed a daily count of controlled medications. The UM stated that the count was performed between two nurses. The UM further stated that the facility used the Controlled Substance Log (CSL) book to document the daily count of controlled medications in the AMDS.

At that time, in the presence of the UM, the surveyor reviewed the CSL book for December 2022 to February 2023. The surveyor identified that the daily count of controlled medications in the AMDS was not documented on the following dates: 12/30/22, 12/31/22, 01/01/23, 01/06/23, 01/07/23, 01/08/23, 01/09/23, 01/26/23, 01/27/23, 01/28/23, 01/29/23, 02/03/23, 02/04/23, 02/05/23, 02/09/23, 02/18/23, 02/19/23, and 02/24/23. The UM confirmed the findings and was not able to provide further information.

On 03/03/23 at 09:51 AM, the surveyor interviewed the Director of Nursing (DON), who confirmed the above findings and stated that the

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expectation was to have the nurses complete the narcotic count, sign, and document on the CSL book to account for discrepancies. The DON further stated that she had a conversation with the UM and that they would ensure that controlled substances were accounted for and documented in the CSL book moving forward.

A review of the facility's "Controlled Substances" policy revealed that the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Scheduled II and other controlled substances. The policy further revealed that the backup narcotic supply must be counted daily by two licensed nurses.

F 812 SS=F Food Procurement,Store/Prepare/Serve-Sanitary F 812
CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(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.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of other facility documentation, it was determined that the facility failed to handle potentially hazardous foods and maintain sanitation in a safe, consistent manner in order to prevent foodborne illness.

This deficient practice was evidenced by the following:

On 02/27/23 from 10:55 AM to 11:40 AM, the surveyor, who was accompanied by the Food Service Director (FSD), observed the following in the kitchen:

1. In the vegetable freezer, the following was observed:
- A bag of oatmeal cookies that were exposed to air and undated.
- A bag of sugar-frozen cookies exposed to air and undated.
- The bottom shelf (base) had an unknown brown substance and brown debris.

2. In the meat freezer, the following was observed:
- A bag of turkey patties that were unlabeled and undated.
- A bag of chopped chicken that was unlabeled and undated
- A pack of turkey burgers (6 patties) unlabeled and undated.
- The bottom shelf (base) had an unknown brown substance and brown debris.

3. The produce refrigerator had an unknown dried brown substance and debris on the bottom (base)

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shelf.

4. In the cook's refrigerator, the following was observed:
- On the second shelf, a turkey deli meat in a hotel pan was loosely covered with plastic wrap, unlabeled and undated.

5. multiple clean hotel (stainless) pans stored on the bottom shelf of the preparation table were noted with powder-like debris. The FSD confirmed the findings and stated that those were clean pans and that the debris on the clean pans was probably from when the staff was preparing food on the table. The FSD later stated that they moved the clean pans to a different location, away from possible splatters and debris from food preparation.

At that time, the FSD confirmed all the findings and stated that food items must be labeled and dated when stored in the freezer and refrigerators.

6. On 02/27/23 at 11:31 AM, in the presence of the FSD, In a sink located next to the cook's refrigerator and the cooking area, the surveyor observed a packaged food placed directly on the sink under running water. The surveyor further observed that the food was not fully submerged in water. When interviewed, the FSD confirmed the findings and stated that the packaged food in the sink was frozen chicken being defrosted.

7. Heavy dust accumulation on the wall-to-floor junctures around the kitchen floor.

8. Unknown dry brown substance on the walls near the hand-washing sink area.

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9. Heavy dirt accumulation, black debris, and white powder-like substance along the side of the cook's refrigerator.

10. Dried grease-dripping on the front door of the main over. The FSD confirmed and stated that it could be an overflow from the flat top's grease cup/drip catcher pan.

11. The steam table area had several cracked tiles on the floor. There were also cracked floor tiles in the sink area with grout missing/split open between the tiles.

12. In the dry storage area/room, there were plastic wraps and loose pieces of paper on the floor, condiment packets (lemon juice packets) were on the floor under the storage shelves, and heavy dark unknown streaks and scuffs were across the floor.

At that time, the FSD confirmed all the findings

The surveyor reviewed the facility's Food and Nutrition Services Policies and Procedures policy with a revision date of 06/15/18 which the Acting Administrator (AA) provided. The policy revealed that food is stored, prepared, and served in a safe and sanitary manner to prevent bacterial contamination and possible spread of infection. It further revealed that Frozen food is thawed in the refrigerator and not at room temperature. Food can be thawed if completely submerged under fast-running water of at least 70 degrees Fahrenheit or below. The policy states under the "Use By" Dating guidelines that food that are marked with the manufacturer's "use by" date that is properly stored can be used until that date as

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long as the product has not been combined with any other food or prepared in any way including portioning. Once a product has been prepared or portioned, a new "use by" date is established.

A review of the facility's policy on Food Storage: Cold Food (HCSG Policy 019) with a revision date of 04/2018, provided by the AA, states that all foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross-contamination.

A review of the facility's policy on Food Storage: Dru Goods (HCSG Policy 018) with a revision date of 09/2017, provided by the AA, states that all dry goods will be appropriately stored in accordance with the FDA Food Code. The policy also included that the storage areas will be neat.

A review of the facility's policy on Equipment (HCSG Policy 027) with a revision date of 09/2017, provided by the AA, revealed that all food service equipment will be clean, sanitary, and in proper working order. The policy further revealed that all equipment will be routinely cleaned and maintained, all food contact equipment will be cleaned and sanitized after every use, and all non-food contact equipment will be clean and debris-free.

F 947 SS=E Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) F 947

§483.95(g) Required in-service training for nurse aides.
In-service training must-

§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must

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be no less than 12 hours per year.

§483.95(g)(2) Include dementia management training and resident abuse prevention training.

§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.

§483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.
This REQUIREMENT is not met as evidenced by:
Based on interview and review of facility documentation, it was determined that the facility failed to maintain an effective tracking system and ensure that Certified Nursing Assistants (CNA) received twelve hours of mandatory in-service training, including dementia management and resident abuse prevention training. This was identified for 5 of 5 CNA files reviewed for in-service education training (CNA #1, #2, #3, #4, and #5).

This deficient practice was evidenced by the following:

On 03/02/23 at approximately 01:39 PM, during an interview with the surveyor, the Facility Educator (FE) stated that she was in charge of staff education. The FE further stated that the facility used an Online Education and Learning Management System, specifically, Healthcare Academy (HCA), an e-learning platform (e-learning, or electronic learning, is delivered via electronic media, typically on the internet) for staff

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F 947	Continued From page 24 education and training. The FE added that CNAs were instructed and expected to complete their annual mandatory in-services training in HCA. At that time, the FE confirmed that it was her responsibility to track the annual mandatory education of CNAs from their hire date and annually after that. The FE further confirmed that there was no formal tracking system of individual staff hours to ensure each CNA completed the mandatory twelve-hour training requirement. The surveyor requested the Individual Employee Education Record from the FE, including all annual mandatory in-services, training, and education completed for the five randomly selected CNAs based on their hire dates. At that time, in the presence of the Facility Educator (FE), the surveyor reviewed the five randomly selected CNAs' in-service education folders, specifically for the twelve-hour mandatory in-service training education hours requirement. CNA#1 had a hire date of 10/25/01. The education/training file revealed CNA#1 completed 1.91 hours of in-person education, including resident abuse prevention training. The FE confirmed that CNA#1 had no record of training in HCA. In addition, there was no completed dementia management training on file. CNA#2 had a hire date of 05/14/21. The education/training file revealed CNA#2 had no in-person education/training completed. The FE confirmed that CNA#2 had no record of training in HCA. In addition, there were no completed dementia management and resident abuse prevention training on file.	F 947		

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CNA#3 had a hire date of 07/01/14. The education/training file revealed CNA#3 completed 1.75 hours of in-person education, including abuse prevention training. The FE confirmed that CNA#3 had no record of training in HCA. In addition, there was no completed dementia management training on file.

CNA#4 had a hire date of 01/24/22. The education/training file revealed CNA#4 completed 1.83 hours of in-person education and 9 hours on HCA, including resident abuse prevention training, for a total of 10.83 hours. The FE confirmed that there was no completed dementia management training on file.

CNA#5 had a hire date of 08/30/21. The education/training file revealed CNA#5 completed 1.16 hours of in-person education, including resident abuse prevention training. The FE confirmed that CNA#5 had no record of training in HCA. In addition, there was no completed dementia management training on file.

On 03/03/23 at approximately 11:08 AM, during an interview, the Administrator was made aware of the findings and stated that the expectation was for all CNAs to complete their mandatory training and education required to have the knowledge to take care of our residents.

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)
315311	A. Building B. Wing	5/1/2023

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 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 F0577 Reg. # 483.10(g)(10)(11) LSC	Correction Completed 04/30/2023	ID Prefix F0583 Reg. # 483.10(h)(1)-(3)(i)(ii) LSC	Correction Completed 04/30/2023	ID Prefix F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 06/01/2023
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 04/30/2023	ID Prefix F0677 Reg. # 483.24(a)(2) LSC	Correction Completed 04/30/2023	ID Prefix F0695 Reg. # 483.25(i) LSC	Correction Completed 04/30/2023
ID Prefix F0755 Reg. # 483.45(a)(b)(1)-(3) LSC	Correction Completed 04/30/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 04/30/2023	ID Prefix F0947 Reg. # 483.95(g)(1)-(4) LSC	Correction Completed 04/30/2023
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	
3/3/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO