STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PHILLIPSBURG, LLC	843 WILBUR AVENUE , PHILLIPSBURG, New Jersey, 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
F0000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #'s: NJ00168770, NJ170940, NJ171761, NJ174599, NJ175858, NJ177242, NJ177261, and NJ175591 Survey Dates: 02/17/25 - 02/24/25 Survey Census: 51 Sample Size: 23 Supplement Sample: 6 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F0000		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition	F0645	1. No residents were immediately affected by this deficient practice. 2. All residents that require a PASRR Level 2 have the potential to be affected by this deficient practice. 3. The [NJ Exec Order 26.4b1] was completed for resident R42. An audit was conducted to ensure all residents that require a PASRR Level 2 have one in place. Staff were inserviced at time of audit, on 2/25/25, to ensure they understood the PASRR Level 1 and Level 2 requirements and processes. 4. The Social Services Director will conduct audits of each new admission to ensure a PASRR Level 2 was completed if required. Audits will be completed weekly x 4 weeks and then monthly x 3 months. All findings will be reported and reviewed by the QAPI committee monthly.	03/31/2025

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F0645 SS = D	Continued from page 1 of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).	F0645		

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F0645 SS = D	Continued from page 2 (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure one out of one resident (Resident (R) 42) reviewed for [redacted] had accurate screenings and/or were referred for a [redacted] review as required following a [redacted]. This had the potential to cause delays in receiving necessary [redacted] services. Total sample was 23. Findings Include: Review of the facility "Preadmission Screening and Resident Review (PASARR)" policy updated on 07/01/24, "Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include a. A resident who exhibits behavioral, psychiatric, or mood-related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR. c. A resident transferred, admitted, or readmitted to the facility following an inpatient psychiatric stay or equally intensive treatment." Review of R42's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R43 was admitted to the facility on [redacted] with diagnoses that included [redacted]. Review of R42's '[redacted]," dated [redacted] and located under the "Misc (Miscellaneous)" tab of the EMR, revealed documentation R43 has a [redacted], did not have [redacted] in [redacted] related to the diagnosis of a [redacted], and had experienced [redacted] treatment	F0645		

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F0645 SS = D	Continued from page 3 NJ Exec Order 2 that was NJ Exec Order 26.4b1 than routine follow-up care in the NJ Exec Order 26.4b1. Review of R43's entire EMR and hard chart revealed no documentation a NJ Exec Orde resident review had been completed for R42. Review of NJ Exec Order 26.4b1 Hospital Discharge Summary Notes, Located under the Misc tab of the EMR, dated NJ Exec Order 26, revealed NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 prior NJ Exec Order 26.4b1 admissions NJ Exec Order 26.4b1 via NJ Exec Order 26.4 on medication years ago, no h/o [history of] NJ Exec Order 26.4b1, currently on NJ Exec Order 26 nightly. The resident was sent to the emergency department on NJ Exec Order 26 reportedly due to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. The patient was admitted to the NJ Exec Order 26.4b1 unit for further NJ Exec Order 26.4b. R43 was in the NJ Exec Order 26.4b unit for NJ E days and released on new medications. During an interview on 02/19/25 at 1:39 PM with the US FOIA (b)(6)), revealed R43 had been out of the facility for NJ Exec Or days in a NJ Exec Order 26.4b facility for NJ Exec Order 26.4b1. When asked about the NJ Exec Order 26 in needing a NJ Exec Order 26.4b1 the US FOIA revealed having some questions as to when to do the NJ Exec Order 26.4 When asked about another NJ Exec Order 26.4b1 see if R43 needed a NJ Exec Order 26.4, the US FOIA stated I never thought about the repeat of the NJ Exec Order 26.4 During an interview on 02/20/25 at 2:57 PM with the US FOIA (b)(6), the US FOIA (b)(6) stated they had requested to appropriate NJ Exec Order 26 to be completed on R43, and they will be reviewing their process. NJAC 8:39-5.1(a)	F0645		
F0695 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	F0695	1. No residents were immediately affected by this deficient practice. 2. All residents that have orders for nebulizer treatments have the potential to be affected by the deficient practice. 3. The order for resident R29 was updated to obtain	03/31/2025

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F0695 SS = D	Continued from page 4 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, interviews, and review of facility policies, the facility failed to ensure a [redacted] assessment was completed prior to initiating a [redacted] treatment and failed to monitor the resident's NJ Exec Order 26.4b1, including response to [redacted] provided, and any changes in the [redacted] condition during the [redacted] treatment. This involved one of 28 sampled residents (Resident (R) 29). Findings include: Review of a policy provided by the facility titled "Nebulizer Therapy" undated. ". . .5.Obtain baseline vital signs . . . 13. Observe resident during the procedure for any change in condition . . . "Documentation" record the following information in the residents medical record ... 3.Resident lung sounds 4. Resident's response to treatment. Review of R29's "Admission Record" in the electronic medical record (EMR) under the "Admissions Record" tab indicated R29 was admitted on [redacted] with diagnoses including NJ Exec Order 26.4b1 Review of R29's care plan located in the EMR under the "Care Plan" tab dated [redacted] indicated R29 was care planned for NJ Exec Order 26.4b1 [redacted] ... The care plan did not address self-administration of the [redacted] Review of Medication Administration Record (MAR), dated [redacted], indicated R29 had an order for [redacted] treatment NJ Exec Order 26.4b1 [redacted] every six hours as needed for NJ Exec Order 26.4b1.	F0695	Continued from page 4 [redacted], NJ Exec Order 26.4b1 before and after [redacted] treatment. LPN1 was educated on completing a [redacted] assessment pre and post [redacted] treatment and to remain with residents when administering [redacted] treatment. All residents who have nebulizer treatment orders were updated to reflect completing a respiratory assessment pre and post nebulizer treatment. Nurses were educated to remain with residents when administering nebulizer treatment and completing pre and post respiratory assessment. 4. The Director of Nursing or Designee will conduct audits of random residents receiving nebulizer treatments to ensure pre and post respiratory assessment was completed and nurse remained with resident during nebulizer treatment. Audits will be completed weekly X 4 weeks and then monthly x 3 months. All findings will be reported and reviewed by the QAPI committee monthly.	

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F0695 SS = D	Continued from page 5 During observation of the medication pass on 02/20/25 at 9:33AM, Licensed Practical Nurse (LPN) 1 administered R29's morning medications in [NJ Ex] room. LPN1 started R29's [NJ Exec Order 26] treatment and returned to the medication cart. LPN1 began to prepare the next resident's medications. LPN1 returned to R29's bedside at 10:05AM and removed R29's [NJ Exec Order 26.4b1] rinsed it out with water and laid it on a towel to air dry. R29 was asleep. LPN1 exited the room. LP1 did not complete a [NJ Exec Order 26.4b] assessment prior to beginning the treatment. During an interview on 02/20/25 at 10:10 AM, LPN1 confirmed she started R29's [NJ Exec Order 26] treatment before leaving the room at 9:33 AM. LPN1 confirmed she did not complete a [NJ Exec Order 26.4b] assessment prior to beginning the treatment, and did not assess R29's [NJ Exec Order 26.4b1] and returned to R29's bedside to complete a [NJ Exec Order 26.4b] assessment checking [NJ Exec Order]. LPN1 stated, the [NJ Exec Order 26.4b] assessment should be done prior to the [NJ Exec Order 26.4] treatment and at the end of the treatment. LPN1 stated the [NJ Exec Order 26.4b] assessment use to be on the MAR with the [NJ Exec Order 26] order, indicating the assessment needed to be done. Review of R29's MAR on 02/20/25 at 11:31 AM, a [NJ Exec Order 26.4b] assessment order was added by [US FOIA (b)(6)] the MAR as follows: Before treatment obtain [NJ Exec Order 26.4b1]. After treatment, obtain [NJ Exec Ord], [NJ Exec Order 26.4b1] and number of minutes spent completing treatment. During an interview on 02/20/25 at 10:31 AM, with [US FOIA (b)(6)]) present, stated that a resident's [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] should always be assessed prior to a [NJ Exec Order 26] treatment with the expectations to be assesses before and after treatment ... NJAC 8:39-25.1(a)	F0695		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F0812	1. No residents were immediately affected by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. All staff were in-serviced at the time of the	03/31/2025

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F0812 SS = F	Continued from page 6 §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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, and facility policy review, the facility failed to ensure kitchen staff properly air-dried pans prior to storage. This failure had the potential to increase the risk of foodborne illness and had the potential to affect 49 of 51 residents who resided in the facility and who received dietary services. There were two residents receiving NJ Exec Order 26.4b1. The facility had a census of 51 residents. Findings include: Review of the facility's policy titled, "Manual Ware washing," dated 10/2024 (sic), revealed, "Policy Statement: All cookware, dishware, and service ware that is not processed through the dish machine will be manually washed and sanitized. Procedures: ... 3. All service ware and cook ware will be air dried prior to storage. Review of the facility's undated policy titled, "Pots and Ware washing," revealed, ". . .9. Air-dry all items on a clean, sanitized drain board or rack. Take care not to stack items to avoid wet nesting ... Wet Nesting: Wet nesting occurs when clean pans, plates, cups, bowls, etc. (et cetera, and other things), are	F0812	Continued from page 6 occurrence regarding the requirement to properly air dry pans prior to storage. 4. The Food Service Director or designee will audit the drying process weekly x 4 weeks and then monthly x 3 months to ensure compliance with the drying process. All findings will be reported and reviewed by the QAPI committee monthly.	

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F0812 SS = F	Continued from page 7 stacked together as they are coming out of the dish machine, or 3 (sic) compartment sink without completely drying first. This action will cause water to pool and, if not dried properly or quickly, can create a breeding ground for bacteria even on clean items. To prevent wet nesting, store clean items in properly filled glass, dish or 3 (sic) compartment racks. Make sure there is no standing water in rims of trays or hotel pans. Always make sure silverware is completely dried and stored in a proper storage bin with lid." During an observation and interview on 02/17/25 at 10:30 AM, the US FOIA (b)(6)) confirmed three pans, 10 inches by 12 inches by 3 inches deep; two pans, 6 inches by 12 inches, by 2 inches; four pans 6 inches by 12 inches, by 8 inches; four pans 12 inches by 24 inches by 3 inches that had been cleaned and stacked for use that were still wet and had food particles on them when they were unstacked. The pans were found to have been stacked wet and not allowed to airdry. The US FO stated, "They should be dry; they weren't completely dry when they were put away. When they're wet it increases the chance of contamination. They need to be rewashed." During an observation and interview on 02/17/25 at 10:35, the US FO confirmed the can opener had paper and a black substance located on the blade. The US FO stated, "The can opener is dirty and needs to be cleaned, it shouldn't have anything on it." NJAC 8:39-17.2(g)	F0812		
F0880 SS = D	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:	F0880	1. No residents were immediately affected by this deficient practice. 2. All residents with foley catheters have the potential to be affected by the deficient practice. 3. The NJ Exec Order 26.4b1 for resident R48 was immediately removed off the floor at the time identified. All residents with NJ Exec Order 26.4b1 were checked to ensure the NJ Exec Order 26.4b1 was off the floor. All staff were re-inserviced to ensure NJ Exec Order 26.4b1 are off the floor. 4. The Director of Nursing or Designee will conduct audits of residents with foley catheters to ensure the catheter bag is not on the floor. Audits will be completed weekly X 4 weeks and then monthly x 3 months. All findings will be reported and reviewed by the QAPI	03/31/2025

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F0880 SS = D	Continued from page 8 §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 §483.71 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; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 8 committee monthly.	

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F0880 SS = D	Continued from page 9 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 policy review, the facility failed to ensure a [NJ Exec Order 26.4b1] was kept off the floor for one of one resident (Resident (R) 48) reviewed for [NJ Exec Order 26] in a total sample of 23 residents. The failure to keep a [NJ Exec Order 26.4b1] the floor increased the risk for R48 developing a [NJ Exec Orde] Findings include: Review of the facility's policy titled, "Indwelling Catheter Care," dated 02/20/25, revealed, "Policy: It is the policy of this facility to ensure that residents with indwelling catheter receive catheter care and maintain their dignity and privacy when indwelling catheters are in use. Procedure ... 3. Privacy bags will be changed out when soiled, with a catheter change or as needed ...5. Ensure drainage bag is located below the level of the bladder to discourage backflow of urine. Drainage bag should not be touching the floor." Review of R48's undated "Admission Record," located in R48's electronic medical record (EMR) under the "Profile" tab revealed R48 was admitted to the facility on [NJ Exec Order 26.4] Review of R48's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [NJ Exec Order 26] indicated R48 had a "Brief Interview for Mental Status (BIMS)" score of [NJ E] out of 15, which indicated the resident was [NJ Exec Order 26.4b1], and indicated R48 had an [NJ Exec Order 26.4b1]. Observation on 02/17/25 at 3:23 PM, revealed, R48 lying [NJ Exec Order 26.4b1]. R48's [NJ Exec Order 26.4b1] was observed lying on the floor next to [NJ E] bed.	F0880		

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F0880 SS = D	Continued from page 10 Observation on 02/18/25 at 3:20 PM, revealed, R48 seated in a wheelchair in the hallway while working with "[redacted] and [redacted] resting on the floor under the wheelchair. During an observation and interview on 02/20/25 at 12:20 PM, Licensed Practical Nurse (LPN) 1 confirmed that R48 was [redacted], and [redacted] bag was lying on the floor next to [redacted] bed. LPN1 stated, "The [redacted] should not be touching the floor, it should never be on the floor. If it is on the floor that increases the risk of infection." NJAC 8:39-19.4	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062101	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PHILLIPSBURG, LLC	843 WILBUR AVENUE , PHILLIPSBURG, New Jersey, 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
S0000	Initial Comments No Information	S0000		
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(a) (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on 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. 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, 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: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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 CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for	S0560	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 or designee to in-service Staffing Coordinator on appropriate staffing ratios and levels. Additional per diem, part-time and full-time were scheduled to meet minimum direct care 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. 4. The Director of Nursing or designee will audit staffing levels weekly x 4 weeks and then monthly x 3 months. All findings will be reported and reviewed by the QAPI committee monthly.	03/31/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062101	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

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S0560	Continued from page 1 the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 09/10/2023 to 09/16/2023, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts and deficient in total staff for residents on 3 of 7 overnight shifts as follows: -09/10/23 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -09/10/23 had 2 total staff for 55 residents on the overnight shift, required at least 4 total staff. -09/13/23 had 3 total staff for 55 residents on the overnight shift, required at least 4 total staff. -09/14/23 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -09/14/23 had 3 total staff for 55 residents on the overnight shift, required at least 4 total staff. -09/15/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -09/16/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. 2. For the week of Complaint staffing from 01/28/2024 to 02/03/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -01/28/24 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -01/31/24 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -02/01/24 had 6 CNAs for 54 residents on the day shift,	S0560		

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S0560	Continued from page 2 required at least 7 CNAs. -02/02/24 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. 3. For the week of Complaint staffing from 02/25/2024 to 03/02/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts and deficient in total staff for residents on 5 of 7 overnight shifts as follows: -02/26/24 had 3 total staff for 50 residents on the overnight shift, required at least 4 total staff. -02/27/24 had 3 total staff for 50 residents on the overnight shift, required at least 4 total staff. -02/28/24 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -02/29/24 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -02/29/24 had 3 total staff for 50 residents on the overnight shift, required at least 4 total staff. -03/01/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -03/01/24 had 3 total staff for 51 residents on the overnight shift, required at least 4 total staff. -03/02/24 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. -03/02/24 had 3 total staff for 51 residents on the overnight shift, required at least 4 total staff. 4. For the week of Complaint staffing from 05/26/2024 to 06/01/2024, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts and deficient in total staff for residents on 3 of 7	S0560		

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S0560	Continued from page 3 overnight shifts as follows: -05/26/24 had 4 CNAs for 52 residents on the day shift, required at least 6 CNAs. -05/28/24 had 3 total staff for 52 residents on the overnight shift, required at least 4 total staff. -05/29/24 had 3 total staff for 52 residents on the overnight shift, required at least 4 total staff. -05/30/24 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -05/31/24 had 3 CNAs for 51 residents on the day shift, required at least 6 CNAs. -05/31/24 had 3 total staff for 51 residents on the overnight shift, required at least 4 total staff. 5. For the 2 weeks of Complaint staffing from 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts and deficient in total staff for residents on 2 of 14 overnight shifts as follows: -07/14/24 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -07/18/24 had 3 total staff for 51 residents on the overnight shift, required at least 4 total staff. -07/24/24 had 3 total staff for 50 residents on the overnight shift, required at least 4 total staff. -07/26/24 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -07/27/24 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs.	S0560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 062101	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

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S0560	Continued from page 4 6. For the week of Complaint staffing from 09/15/2024 to 09/21/2024, the facility was deficient in CNA staffing for residents on 4 of 7 day shifts as follows: -09/15/24 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -09/16/24 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. -09/17/24 had 4 CNAs for 53 residents on the day shift, required at least 7 CNAs. -09/19/24 had 4 CNAs for 52 residents on the day shift, required at least 6 CNAs. 7. For the 2 weeks of staffing prior to survey from 02/02/2025 to 02/15/2025, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -02/02/25 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -02/06/25 had 4 CNAs for 50 residents on the day shift, required at least 6 CNAs. -02/08/25 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -02/09/25 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs.	S0560		
S1680	Mandatory Nurse Staffing CFR(s): 8:39-25.2(b)(1)&(2) (b) The facility shall provide nursing services by registered professional nurses, licensed practical nurses, and nurse aides (the hours of the director of nursing are not included in this computation, except for the direct care hours of the director of nursing in facilities where the director of nursing provides more than the minimum hours required at N.J.A.C. 8:39-25.1(a) above) on the basis of:	S1680	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 or designee to in-service Staffing Coordinator on appropriate staffing ratios and levels. Additional per diem, part-time and full-time staff were scheduled to meet minimum staffing levels. The facility has advertised open jobs through online recruitment platforms. The facility has conducted job	03/31/2025

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S1680	Continued from page 5 1. Total number of residents multiplied by 2.5 hours/day; plus 2. Total number of residents receiving each service listed below, multiplied by the corresponding number of hours per day: Wound care 0.75 hour/day Nasogastric tube feedings and/or gastrostomy 1.00 hour/day Oxygen therapy 0.75 hour/day Tracheostomy 1.25 hours/day Intravenous therapy 1.50 hours/day Use of respirator 1.25 hours/day Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on review of the Nurse Staffing Reports for the weeks of 02/02/2025 to 02/15/2025, it was determined that the facility failed to provide at least minimum staffing levels for 2 of 14 days . The required staffing hours and actual staffing hours are as follows: For the week of 02/02/25 Required Staffing Hours: 155.25 -02/22/25 had 152 actual staffing hours, for a difference of -3.25 hours. -02/06/25 had 152 actual staffing hours, for a difference of -3.25 hours.	S1680	Continued from page 5 fairs and partnered with local schools for newly licensed or certified staff. 4. The Director of Nursing or designee will audit staffing levels weekly x 4 weeks and then monthly x 3 months. All findings will be reported and reviewed by the QAPI committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 02/24/25 and 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 at Phillipsburg, LLC is a three-story building with a basement built in the 1960's with a one story addition in 1991. It is composed of Type II protected construction. The facility is divided into four - smoke zones. The generator powers approximately 60 % of the building per the Maintenance Director. The current occupied beds are 51 of 60.	K0000		
K0311 SS = F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is NOT MET as evidenced by: Based on observations and interview, the facility failed to ensure two of 10 fire rated door assemblies	K0311	No residents were immediately affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) was educated on the requirement for fire rated door assemblies for stairway exit doors to be equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code. All hardware has been ordered as of 4/6/2025 (receipt attached). Hardware will be replaced on the deficient doors by 4/16/2025. Pictures attached - Door1 and Door2. The Maintenance Director or designee will audit a sample of 3 stairway exit doors for 4 weeks and then monthly x2 to ensure compliance with the Life Safety Code. All findings will be reported and reviewed by the QAPI committee monthly.	04/16/2025

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

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K0311 SS = F	Continued from page 1 for stairway exit doors were equipped with approved fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.7.2. This deficient practice had the potential to affect all 51 residents and was evidenced by the following: Observations on 02/24/25 between 11:32 AM and 2:30 PM of all the facility's stairway fire rated door assemblies revealed they were equipped with panic hardware which violated the listing of the rated fire door assembly. During an interview at the time of observations, the US FOIA (b)(6) confirmed the stairway exit doors were equipped with panic hardware. NJAC 8:39-31.2(e)	K0311		
K0341 SS = F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure the manual fire alarm pull station was secured in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) 17.14.3. This deficient practice had the potential to affect all 51 residents and was evidenced by the following: Observation on 02/24/25 at 1:40 PM revealed the manual fire alarm pull station located next to the kitchen in the basement was broken loose from the wall.	K0341	No residents were immediately affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) was educated on the requirement for manual fire alarm pull stations to be secured in accordance with NFPA 72 National Fire Alarm and Signaling Code. The Maintenance Director correctly affixed the pull station to the wall. The Maintenance Director or designee will audit a sample of 3 fire alarm pull stations for 4 weeks and then monthly x2 to ensure compliance with NFPA 72 National Fire Alarm and Signaling Code. All findings will be reported and reviewed by the QAPI committee monthly. Picture attached 4/4/25.	03/17/2025

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K0341 SS = F	Continued from page 2 During an interview at the time of the observation, the US FOIA (b)(6) verified the manual fire alarm pull station was loose from the wall. The Maintenance Director stated the vendors bringing food and other items into the kitchen were always knocking the manual pull station off the wall. NJAC 8:39-31/1(c), 31.2(e) NFPA 72	K0341		
K0355 SS = F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure one out of 36 fire extinguishers were serviced annually and failed to ensure one out of 36 fire extinguishers was mounted properly in accordance with NFPA 10, Standard for Portable Fire Extinguishers (2010 Edition) 7.3.1.1.1 and 6.1.3.4. This deficient practice had the potential to affect all 51 residents and was evidence by the following: An observation on 02/24/25 at 12:35 PM of a 10 lbs. NJ Exec fire extinguisher in the Boiler room revealed the fire extinguisher had not been serviced annually. The last documented evidence of the fire extinguisher being serviced was May 2023. An observation on 02/24/25 at 01:35 PM of a 10 lbs. NJ Exec fire extinguisher outside the employees' breakroom revealed the fire extinguisher was mounted with unapproved two self-tapping screws and mounted on a bracket. During an interview at the time of each observation,	K0355	No residents were immediately affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) was educated on the requirement for fire extinguishers to be serviced annually as well as properly mounted in compliance with NFPA 10, Standard for Portable Fire Extinguishers. The fire extinguisher in the boiler room was replaced with a properly inspected fire extinguisher. The bracket was replaced on the fire extinguisher near the break room. The maintenance director or designee will audit a sample of 3 fire extinguishers for 4 weeks and then monthly x2 to ensure compliance with NFPA 10, Standard for Portable Fire Extinguishers. All findings will be reported and reviewed by the QAPI committee monthly. Picture attached 4/4/25.	03/17/2025

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K0355 SS = F	Continued from page 3 the US FOIA (b)(6) confirmed the fire extinguisher was not serviced and the fire extinguisher was not mounted properly. NJAC 8:39-31.1(c), 31.2(e) NFPA 10	K0355		
K0761 SS = F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 51 residents and was evidenced by the following: A review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence that the facility's fire doors were inspected. Observations on 02/24/25 from 11:32 AM to 2:30 PM of the facility's fire doors revealed the doors lacked the	K0761	No residents were immediately affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) was educated on the requirement for the facility having an annual fire door inspection. The facility will have the required annual fire door inspection conducted by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA101 Life Safety Code (2012 Edition) Section 7.2.1.15 by 4/30/2025. The Maintenance Director or designee will audit any required annual inspection weekly x4 and then monthly x2 in order to ensure that the facility meets annual inspection requirements in the Life Safety Code. All findings will be reported and reviewed by the QAPI committee monthly. Picture attached on 4/4/25. Inspector's letter of inspection attached on 4/30/25. Inspection took place on 3/25/25.	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

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K0761 SS = F	Continued from page 4 required inspection tags to be placed on the doors after completed inspections. During an interview at the time of each observation, the US FOIA (b)(6) confirmed the fire doors had not been inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K0761		
K0914 SS = F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure electrical outlet testing was conducted annually in accordance with NFPA 99 Health Care Facilities Code (2012 edition) Section 6.3.3.2.1. This deficient practice had the potential to affect all 51 residents and was evidenced by the following: A review of the facility's untitled fire inspection binder provided by the US FOIA (b)(6) revealed no	K0914	No residents were immediately affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) was educated on the requirement for ensuring that electrical outlet testing is conducted annually. The required tension testing will be completed by 3/31/2024.(Log uploaded.) The Maintenance Director or designee will audit any required annual inspection weekly x4 and then monthly x2 in order to ensure that the facility meets annual inspection requirements in the Life Safety Code. All findings will be reported and reviewed by the QAPI committee monthly.	03/31/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PHILLIPSBURG, LLC	843 WILBUR AVENUE , PHILLIPSBURG, New Jersey, 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
K0914 SS = F	Continued from page 5 documented evidence electrical outlet testing had been completed on the electrical outlets in the past 12 months. During an interview on 02/24/25 at 11:30 AM, the US FOIA (b)(6) stated the electrical outlet testing was not completed. NJAC 8:39-31.2(e) NFPA 99	K0914		
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste 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 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by:	K0918	No residents were immediately affected by this deficient practice. All residents have the potential to be affected by this deficient practice. The US FOIA (b)(6) was educated on the requirement for monthly load tests on the facility generator and the requirement for a remote manual pull stop station to be installed for the generator. All load tests since the date of the deficient practice have been completed per the requirement. The vendor is contracted as of 3/20/2025 to install the remote manual pull stop. The Maintenance Director or designee will audit the previous required monthly generator load test weekly x4 and then monthly x2 in order to ensure that the facility meets inspection requirements in the Life Safety Code. All findings will be reported and reviewed by the QAPI committee monthly.	04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

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

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K0918 SS = F Bldg. 01	Continued from page 6 Based on record review and interview, the facility failed to ensure monthly load tests were conducted on the emergency generator; and failed to ensure the generator was equipped with a remote emergency stop switch in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.4.1. and 5.6.5.6. This deficient practice had the potential to affect all 51 residents and was evidenced by the following: A review of the facility's untitled generator reports dated for the year 2024, provided by the facility, revealed monthly load tests were not completed on the emergency generator for the months of April 2024, June 2024, July 2024, nor August 2024. An observation on 02/24/25 at 11:38 AM revealed that the emergency generator was not equipped with a remote manual stop station. During an interview on 02/24/25 at 2:30 PM, the US FOIA (b)(6) confirmed the monthly load tests were not completed and stated that this was when the facility was without a US FOIA (b)(6). The US FOIA (b)(6) also confirmed the emergency generator was not equipped with a remote manual stop station. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K0918		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315311	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2025

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

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E0000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 02/24/25. The facility was found to be in compliance with 42 CFR 483.73.	E0000		

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 reverse for further 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.

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