STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315221	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hamilton, LLC	56 Hamilton Avenue Passaic, NJ 07055

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner to prevent food borne illness. This deficient practice was observed and evidenced by the following:On 09/02/2025 at 10:30 AM, the surveyor in the presence of the Food Service Director (FSD) toured the kitchen and observed the following: 1. In the reach in refrigerator the surveyor observed 3 blocks of pre-sliced cheese wrapped in plastic film with no open date or use by date and a foil covered plate of breakfast foods with no label, opened or use by date. The FSD stated all opened or left over foods should have a prepared or opened on date and a use by date to prevent residents from receiving spoiled or expired foods. The FSD confirmed that the unlabeled foods would be discarded.2. In the walk-in cooler, the surveyor observed a tray of souffle cups of individually portioned canned fruits and pureed canned fruits. Neither the containers nor the tray was labeled with open dates or use-by dates. The FSD stated all opened foods should be labeled with opened and use by dates to prevent residents from receiving spoiled or expired foods. The FSD confirmed that the unlabeled food would be discarded.3. On a rolling cart near the tray assembly line, the surveyor observed several stacks of plate covers that were wet nested. The FSD confirmed this cart, and the covers were in place to be used on the upcoming lunch service. The FSD confirmed that dishware and serving vessels should not be wet nested to prevent the growth of bacteria. The FSD assigned a staff member to remove the covers for rewashing immediately.On 9/8/2025 at 10:30 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Regional [NAME] President of Clinical Services to discuss the above observations and concerns. The administration confirmed that all opened and prepared foods need to be labeled with an open date and a use by date to prevent residents from receiving expired or spoiled foods. The DON acknowledged that wet nesting of dishes should not occur to prevent bacterial growth.A review of the facility's policy Food Safety Requirements dated 9/1/24 revealed . Practices to maintain safe refrigerated storage include labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so that it is used by its use-by date, or frozen (where applicable)/discarded.On 9/10/25 at 1:00 PM, the surveyor team met with the LNHA and DON. No further information provided by the facility.NJAC 8:39-17.2(g)

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain the call bell within reach of residents. This deficient practice was identified for 1 of 22 residents reviewed for accommodation of needs (Resident #96), and was evidenced by the following: On 09/04/25 at 8:07 AM, the surveyor observed Resident #96 in bed. The surveyor observed the Resident's call light pull cord (used to summon staff for assistance) affixed to the upper aspect of the right-side rail, not within his/her reach. The resident stated, There should be a string around here somewhere, but I can't seem to find it, so I can't call for help. The surveyor reviewed the medical record for Resident #96. A review of the admission Record reflected the Resident was admitted to the facility with diagnoses that included but were not limited to; diabetes mellitus (too much sugar in the blood), malignant neoplasm of the breast (cancer of the breast), and osteoarthritis (a degenerative joint disease) of the right knee. A review of Resident #96's Quarterly Minimum Data Set (MDS), an assessment tool dated 8/25/25, revealed Resident #96 had a Brief Interview for Mental Status score of 15 out of 15, which indicated the resident's cognition was intact. The MDS further revealed that the resident required maximum assistance from staff for activities of daily living care. A review of Resident #96's Individualized Care Plan (CP) initiated on 7/13/25 had a focus that indicated the resident was at risk for falls, with interventions that included but were not limited to: ensure the resident's call light is within reach and encourage the resident to use it for assistance as needed. On 9/4/25 at 8:18 AM, the surveyor showed the Certified Nursing Assistant (CNA) assigned to Resident #96's care the call light pull cord affixed to the upper aspect of the right-side rail, not within the resident's reach. The CNA confirmed that she should have placed the pull cord within the resident's reach. On 9/8/25 at 12:28 PM, the survey team met with the Licensed Nursing Home Administrator, Director of Nursing, and VP of Clinical Operations to discuss the above observations and concerns. A review of the facility's policy, Call Lights, dated 1/25, revealed:Always position the call light conveniently for use and within the reach of the resident. NJAC 8:39-27.1 (a); 31.8 (c) (9)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint #NJ 401472 Based on observation, interview, and pertinent facility documentation, it was determined that the facility failed to a.) maintain a homelike environment that was clean, safe, and sanitary in 3 out of 24 resident rooms (rooms 114,116, and 123) and b.) ensure that personal clothing items, specifically socks, were returned after being laundered to 5 out of 5 residents who attended the resident council meeting (Resident #25, 67, 70, 83, 85). Additionally, Resident # 96 complained that their socks were not returned after being laundered. This deficient practice was evidenced by the following:1. On 9/2/2025 at 11:06 AM, the surveyor observed in room [ROOM NUMBER] a broken dresser drawer, peeling paint with exposed plaster and sheet rock to the right of the sink. On 9/2/25 at 12:00 PM, the surveyor observed in room [ROOM NUMBER]-2 a portable oxygen tank heavily soiled with rust and a brown substance, with a swarm of flying insects around the oxygen tank. The surveyor observed the wall by the headboard was cracked with exposed sheet rock and was heavily soiled with a brown substance. The armoire was observed to have had broken drawers and large cracks with missing pieces. On 9/4/25 at 8:07 AM, the surveyor observed that the bathroom floor in room [ROOM NUMBER] was heavily soiled with a brown substance around the base of the toilet. Additionally, the toilet was soiled with a yellow substance, and the toilet paper dispenser was heavily rusted. The metal panels on the bottom of the door, both inside and outside, were also heavily soiled with a brown material. On 9/4/25 at 8:43 AM, the surveyor and the Director of Housekeeping (DHK) entered room [ROOM NUMBER] and observed an unpleasant, offensive smell in the bathroom. They noted the floor was soiled with a yellow material, and a large plastic bag was on the floor full of soiled linens, with insects swarming the bag. The DHK and the surveyor also observed that the garbage can was overflowing with trash, which was also scattered on the floor. The surveyor and DHK further observed that in room [ROOM NUMBER]-3 the floor was soiled with food and liquids, and the bedside table had a sticky yellow substance on it with flying insects swarming the area. On 9/4/25 at 8:45 AM, during an interview with the surveyor, the maintenance staff member acknowledged the broken armoire in room [ROOM NUMBER] and the disrepair of the wall behind the bed. The maintenance staff member stated that the facility was aware of the broken dresser and had ordered a new one about 2 months ago and had also ordered new panels for the areas behind the headboards. On 9/4/25 at 8:50 AM, during an interview with the surveyor, the Director of Maintenance (DOM) stated that the facility staff were responsible for listing repairs that needed to be done in the book that was kept at the nurses' station. At that time, the surveyor and DOM reviewed the book and observed that no repairs had been documented for rooms 114, 116, or 123, but confirmed that the concerns in all three rooms should have been addressed. On that same date, at that same time, the DHK confirmed that rooms [ROOM NUMBERS] needed cleaning and that the rooms and bathrooms failed to meet the clean, comfortable, homelike environment standards. 2.) On 9/4/25 at 8:07 AM, during an interview with the surveyor, Resident #96 stated that they were missing all of their socks. The resident further stated that he/she had mentioned it to the housekeeping staff and nursing staff many times, but they still had not returned the socks. On 9/4/25 at 10:30 AM, the surveyor conducted the Resident Council meeting with 5 residents whom the facility chose to attend. All 5 residents stated that they were missing socks. They further stated that they had informed the housekeeping staff and the nursing staff but still had not received their socks back. The 5 residents stated it had been over a month since their socks went missing. On 9/8/25 at 8:10 AM, during an interview with the surveyor, in the presence of the Housekeeping Director (HKD), the housekeeping staff member responsible for laundry stated that several residents had complained to her that their socks were not returned after being laundered. The housekeeping staff stated that she was very busy and had not had time to pair or deliver the residents' socks in over a month. At that time, the HKD also confirmed (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the residents had complained to her several times about their missing socks. The surveyor toured the laundry room and observed five large plastic bags full of residents' personal socks, which the DHK and housekeeping staff member acknowledged was unacceptable. On 9/8/25 at 10:05 AM, the surveyor discussed the above observations and concerns with the Licensed Nursing Home Administrator, Director of Nursing, and the VP of Clinical Operations. The VP of Clinical Operations stated that she had observed the five large bags of residents' socks in the laundry room and that it was unacceptable. A review of the facility's policy, Laundry Delivery, reflected .Laundry is done and returned within 24-72 hours . A review of the facility's policy, Handling Clean Linen, dated 9/1/24, reflected .It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary manner . A review of the facility's policy, Safe and Homelike Environment, dated 10/1/24, reflected .In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment, allowing residents to use their personal belongings . A review of the facility's policy, Environmental Services Inspection, reflected .It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. NJAC 8:39 31.4 (a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview and review of pertinent facility documentation, it was determined that the facility failed to monitor the nutritional status for 1 of 2 residents reviewed (Resident #2), specifically by not following a physician's orders for monitoring of Resident #2's weights.The deficient practice was evidenced by the following:On 9/3/25 at 11:29 AM, the surveyor observed Resident #2 in bed with the head of bed elevated, eye opened and not verbal.A review of Resident #2's admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; Anoxic brain damage (an injury to the brain caused by lack of oxygen), functional quadriplegia (the loss of functional use of the upper and lower body), gastrostomy for enteral feeding (full nutrition is provided through a tube directly into the resident's stomach) and aphasia (the inability to produce or understand speech) A review of Resident #2's annual Minimum Data Set (MDS), an assessment tool, reflected that the resident was severely cognitively impaired.A review of the resident's Physician Order Summary report reflected the following physician's orders (POs): 1. obtain the resident's weight one time a week on Fridays for a 4 week period initiated on 8/16/24; 2. PO dated 8/16/2024 to weigh resident on day shift every month on the 1st day of the month and 3. a PO dated 12/24/2024 to weigh resident on the day shift every month on the 1st day of the month. A review of Resident #2's medical record did not indicate that a weight was obtained on 9/6/2024 as required by order #1. The medical record did not indicate a weight was obtained on 10/1/2024 or 11/1/2024 as required by order #2. The medical does not indicate a weight was obtained on 1/1/2025, 3/1/2025 or 5/1/2025 as required by order #3.On 9/5/2025 at 10:00 AM, the surveyor interviewed the unit manager (UM) for the 1st floor. The UM verbalized weights were done at least monthly on all residents and more frequently if ordered. The UM stated that the Certified Nursing Assistants (CNAs) would weigh the residents and reports the finding to the UM or to the nurse assigned to the resident. The UM or the Nurse assigned to the resident would record the weights in the resident's medical record. On 9/5/2025 at 10:10 AM, the surveyor interviewed the facility's registered dietician RD. The RD stated that the CNAs were responsible for obtaining resident weights and reporting the findings to the UM or the nurse assigned to the resident's care. The UM or the floor nurse recorded the weights in the resident's medical record after being reviewed by the RD. The RD acknowledged that following a PO and obtaining weights was important for residents who receive enteral nutrition. On 9/5/2025 at 11:00 AM, during an interview with the surveyor, the Director of Nursing (DON) confirmed that a physician's order for a specific weight schedule should be followed accurately. The DON acknowledged that monitoring weights was important in monitoring resident's nutritional status.On 9/9/2025 at 11:10 AM, the surveyor met with Licensed Nursing Home Administrator (LNHA) and DON to discuss the above observations and concerns. The LNHA and DON confirmed that the weights were not taken per the PO.A review of the facility policy, Weight monitoring reflected in section #5 A weight monitoring schedule will be developed upon admission for all residents and. Weights should be recorded at the time they were obtained. NJAC 8:39- 27.2(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to obtain a physician's order for the administration of oxygen therapy and failed to ensure that respiratory equipment was stored in accordance with infection control measures for 1 of 2 residents reviewed for respiratory care (Resident # 44). This deficient practice was evidenced by the following:Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and wellbeing, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 09/02/2025 at 12:00 PM, the surveyor observed a portable oxygen tank in room [ROOM NUMBER] on the left side of Resident #44's bed. The surveyor observed that the oxygen tank was heavily soiled with a brown substance, and the undated nasal cannula tubing was on the floor. On 9/2/25 at 12:30 PM, the surveyor observed Resident #44 in the 1st floor nursing unit in front of the nurses' station. The resident did not respond to the surveyor's greeting. A review of Resident #44's admission Record reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; epilepsy (a disorder in which nerve cell activity in the brain is disturbed which causes seizures), chronic obstructive pulmonary disease (a group of lung conditions that cause airflow obstruction and breathing problems) and vascular dementia (changes to memory, thinking, and behavior resulting from conditions that affect the blood vessels in the brain.) A review of the resident's current Physician Order Summary report reflected that there was no physician's order for the use of Oxygen. A review of Resident #44's annual Minimum Data Set (MDS), an assessment tool, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 5 out of 15, which indicated severe cognitive impairment. Further review of the MDS in Section O did not indicate that the resident received Oxygen Therapy. A review of Resident #44's individualized care plan (ICP) with an initiated date of 8/24/22; revised date of 7/14/24, and a target date of 7/14/25, that included a focus area that the resident had an alteration in respiratory status due to chronic obstructive pulmonary disease with interventions that included but were not limited to; to administer oxygen as needed per physician order, to monitor oxygen saturation on room air and on oxygen, and to monitor oxygen flow rate and response. On 9/2/25 at 12:32 PM, during an interview with the surveyor, the Licensed Practical Nurse (LPN) acknowledged that the oxygen tubing was not dated, on the floor, and that the oxygen tank was heavily soiled with insects flying around it. The LPN stated that she should have discarded the oxygen tubing this morning when she first saw it on the floor. On 9/3/25 at 12:16 PM, during an interview with the surveyor, the LPN stated that the resident did not have an order for oxygen and was not sure why it was in his/her room yesterday. The LPN stated that it may have been administered when the resident had seizures. On 9/9/25 at 12:55 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Regional Nurse to discuss the above observations and concerns. The DON confirmed that Resident #44 should have had a physician's order for the administration of oxygen per the resident's ICP and that the oxygen tubing should be dated and stored in a plastic bag for infection control measures. A review of the facility's policy, Oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration, dated 5/2025, reflected .Oxygen is administered under the orders of a physician, except in the case of an emergency. In such a case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control .The resident's care plan shall identify the interventions for oxygen therapy . 8:39-31.4 (a)