STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315460	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	**336 PROSPECT AVE , HACKENSACK, New Jersey, 07601**

(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 The NJDOH conducted a Complaint survey on 10/31/2025. The survey was officially completed on 10/31/2025. Complaint #: 384189, 2578359, 384196 COMPLAINT SURVEY: 10/31/25 CENSUS: 118 SAMPLE SIZE: 3 A Complaint Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. The facility is in compliance with the Requirements of 42 CFR part 483, subpart B, for Long Term Care Facilities.	F0000		11/17/2025

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: 056300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S0000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S0000		11/17/2025
S0560	Mandatory Access to Care CFR(s): 8:39-5.1(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 interviews and review of other facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This deficient practice was identified for 14 out of 14-day shifts and 8 of 14-evening shifts reviewed. 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. "Direct care staff member" means any registered professional nurse, licensed practical nurse, or certified nurse aide who is acting in accordance with that individual's authorized scope of practice and pursuant to documented employee time schedules. The following ratio(s) were effective on 02/01/2021:	S0560	Residents affected by deficient practice: All Residents are affected by the deficient practice. The following corrective action will be taken for those residents found to be affected: DON/Designee will review staffing needs with staffing coordinator/HR designee regularly and check that staff par levels meet the ratios. HR Designee will continue to advertise staffing needs through recruitment agencies. No negative outcomes were observed. Identify those individuals who could be affected by the deficient practice: All residents have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: The following measures and systemic changes will be put in place to attempt to prevent the deficient practice from recurring: DON/Designee will review staffing needs with staffing coordinator/HR designee daily on an ongoing basis for progress and to monitor mandatory staffing requirements. HR Designee will continue to maintain a recruitment & hiring log, to track all C.N.A. applicants and outcomes.	11/03/2025

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: 056300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE , HACKENSACK, New Jersey, 07601

(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
S0560	Continued from page 1 One 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 the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility as documented below: For the 2 weeks of AAS-11 staffing, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in CNAs to total staff on 8 of 14 evening shifts as follows: -10/12/25 had 6 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/12/25 had 6 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -10/13/25 had 8 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/13/25 had 6 CNAs to 15 total staff on the evening shift, required at least 7 CNAs. -10/14/25 had 8 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/14/25 had 6 CNAs to 17 total staff on the evening shift, required at least 8 CNAs. -10/15/25 had 8 CNAs for 113 residents on the day shift, required at least 14 CNAs. -10/15/25 had 8 CNAs to 18 total staff on the evening shift, required at least 9 CNAs. -10/16/25 had 8 CNAs for 117 residents on the day shift, required at least 15 CNAs. -10/16/25 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs.	S0560	Continued from page 1 Facility to continue to post open C.N.A. positions on job sites and job fairs. Current C.N.A. rates are at market rate. Measures or systemic changes to ensure that the deficiency will not recur: The following programs will be put into place to monitor the continued effectiveness of the systemic changes: HR Designee will discuss staffing recruitment and retention plan monthly. Recommendations will be reviewed submitted quarterly to The Quality Assurance Performance Improvement (QAPI) Committee, chaired by the Administrator. Audits will be completed weekly X 4 weeks. Results of audit process will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Date of Completion: 11/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

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S0560	Continued from page 2 -10/17/25 had 8 CNAs for 116 residents on the day shift, required at least 14 CNAs. -10/17/25 had 6 CNAs to 17 total staff on the evening shift, required at least 8 CNAs. -10/18/25 had 7 CNAs for 116 residents on the day shift, required at least 14 CNAs. -10/19/25 had 5 CNAs for 116 residents on the day shift, required at least 14 CNAs -10/20/25 had 10 CNAs for 116 residents on the day shift, required at least 14 CNAs. -10/21/25 had 8 CNAs for 118 residents on the day shift, required at least 15 CNAs. -10/21/25 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -10/22/25 had 10 CNAs for 117 residents on the day shift, required at least 15 CNAs. -10/23/25 had 8 CNAs for 117 residents on the day shift, required at least 15 CNAs. -10/24/25 had 10 CNAs for 117 residents on the day shift, required at least 15 CNAs. -10/25/25 had 9 CNAs for 117 residents on the day shift, required at least 15 CNAs. -10/25/25 had 6 CNAs to 16 total staff on the evening shift, required at least 8 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)) on the basis of: 1. Total number of residents multiplied by 2.5 hours/day; plus	S1680	Residents affected by deficient practice: All Residents are affected by the deficient practice. The following corrective action will be taken for those residents found to be affected: DON/Designee will review staffing needs with staffing coordinator/HR designee regularly and check that staff par levels meet the required ratios. HR Designee will continue to advertise staffing needs through recruitment agencies. No negative outcomes were observed. Identify those individuals who could be affected by the deficient practice:	11/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2025

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S1680	Continued from page 3 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 prior to survey from 10/12/2025 to 10/25/2025, it was determined that the facility failed to provide at least minimum staffing levels for 1 of 14 days. The required staffing hours and actual staffing hours are as follows: For the week of 10/19/2025 Required Total Staffing Hours: 331.50 -10/19/25 had 320 actual staffing hours, for a difference of -11.50 hours.	S1680	Continued from page 3 All residents have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: The following measures and systemic changes will be put in place to attempt to prevent the deficient practice from recurring: DON/Designee will review staffing needs with staffing coordinator/HR designee daily on an ongoing basis for progress and to monitor mandatory staffing requirements. HR Designee will continue to maintain a recruitment & hiring log, to track all Nurse applicants and outcomes. Facility to continue to post open Nurse positions on job sites and job fairs. Current Nurse rates are at market rate. Measures or systemic changes to ensure that the deficiency will not recur: The following programs will be put into place to monitor the continued effectiveness of the systemic changes: HR Designee will discuss staffing recruitment and retention plan monthly. ecommendations will be reviewed submitted quarterly to The Quality Assurance Performance Improvement (QAPI) Committee, chaired by the Administrator. Audits will be completed weekly X 4 weeks. Results of audit process will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Date of Completion: 11/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315460	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan off Correction was conducted on 12/5/2025 in relation to the 10/31/2025 Complainant survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities.	F0000		

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056300	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025

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S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 12/5/2025 in relation to the 10/31/2025 State of New Jersey Complainant survey. The facility was found to be in compliance with the Standards in New Jersey Administrative Code, Chapter 8:30, Standards of Licensure of Long Term Care Facilities.	S0000		

Office of Primary Care and Health Systems Management

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