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 01/29/2026

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 Complaint NJ#s: 384180, 384182, 384183, 384186 (186712), 384188, 384190, 2573473, 2615149, and 2668945 Survey Date: 1/21/26-1/29/26 Census: 117 Sample: 28 sample + 3 closed records =31 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F0000		01/29/2026
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 - §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	F0812	No residents were affected by this deficient practice. Upon notification U. S. FOIA (b) (2) removed dented cans and placed dented cans in "dented can area." The items in freezer 1 and freezer without dates and/ or labels were removed and discarded. The items in walk in refrigerator 1 that where expired were discarded. The kitchen hoods were adjusted to not have gaps. The stove tops, oven and frying pans were cleaned to ensure they were free of any black crusted substance. A trash bin was immediately placed next to the second hand wash station. All residents have the potential to be affected by this deficient practice. Administrator educated U. S. FOIA (b) (2) and kitchen staff regarding dented cans, labeling and dating, ensuring the kitchen hoods do not have gaps, kitchen cleanliness and ensuring there is a trash bin near hand washing stations. Administrator / designee will conduct and audit weekly x 4 weeks then monthly x 2 months to ensure there are no dented cans in circulation, that	02/02/2026

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

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F0812 SS = F	Continued from page 1 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review, it was determined that the facility failed to; a.) store potentially hazardous foods in a manner to prevent food borne illness, b.) failed to properly label and date food items to ensure safety and prevent contamination, c.) failed to discard expired and unsafe food in accordance with facility policy, d.) failed to maintain kitchen equipment and utensils in a sanitary manner to prevent contamination from foreign substances and the potential for development of food borne illness, and e.) failed to maintain essential kitchen equipment in safe operating condition. This deficient practice was evidenced by the following: On 1/21/26 at 09:45 AM, in the presence of the U. S. FOIA (b) (2) the surveyor observed the following: Dry Storage Area: 1.In the dry storage room, the surveyor observed six dented cans located on the can storage rack that was accessed by kitchen staff for meal preparation. The surveyor observed three cans containing peaches and three cans containing marinara sauce. Each dented can had a dent measuring 1½ - 2 inches along the seam. The surveyor observed a designated "Dented Can" area located on the bottom shelf of a separate shelving unit that contained additional dented cans. The U.S. FOIA immediately removed the six dented cans from the can storage rack after surveyor observation and placed them in the "Dented Can" area. Walk-In Freezer #1: 2.The surveyor observed 12 single serve ice cream servings prepared from a large ice cream container in small plastic clear containers on a tray on the shelf of the freezer with no label identifying the date of preparation or the date of use-by. The U.S. FOIA stated that her expectation was that the items were from the previous day but the items did not contain a label.	F0812	Continued from page 1 all items are securely covered, dated and labeled, that there is a trash bin adjacent to the hand washing sinks and that the staff maintains a sanitary kitchen. The results of the audit will be reviewed at the monthly quality assurance performance improvement meetings. Date of Completion: 01/23/2026	02/02/2026

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F0812 SS = F	Continued from page 2 Walk-In Freezer #2: 3.The surveyor observed a box of items containing muffins and bread that the [redacted] stated were gluten free. In the open box, the surveyor observed a container of muffins that contained two muffins with two missing. The lid on the muffins was off and did not contain a label dating when the item was opened or when the item should be used by. In addition, the surveyor observed the gluten free box contained two bags of bagels, each with two bagels left inside. The bags were not closed or sealed. The bags of bagels also did not contain a date indicating when they were opened and when they should be used by. At the bottom of the box, the surveyor observed a single bagel wrapped in saran wrap with no label indicating when it was opened or when the item should be used by. The [redacted] stated she "was not sure how long the loose item was in the freezer". The [redacted] discarded all the items that did not have a label following surveyor observation. Walk-In Refrigerator #1: 4.The surveyor observed a large plastic container of Italian dressing with a label that noted Open date – 1/14/26 and EOD (End of Day) date 1/20/26. The [redacted] removed the item from the refrigerator and stated the item should have been removed and discarded on the previous day, on 1/20/26. The [redacted] discarded the item at that time. 5.The surveyor observed sliced turkey wrapped in saran wrap on a tray with lunch meat items. The sliced turkey had an open date of 1/18/26 and an EOD date 1/20/26. The [redacted] stated that the item should have been used or discarded the previous day and then proceeded to dispose of the item. Kitchen Equipment: 6.Above the stove, the surveyor observed the ventilation hoods or exhaust hoods above the stove which contained 14 hoods. The surveyor observed two of the 14 hoods contained small bends in the bottom of the hood closest to the floor that created a ¼ inch gap. 7.The surveyor observed a six burner stove top with a black crusted substance that was easily lifted with the tip of the surveyor's pen. The [redacted] stated that the stove tops were cleaned daily. The [redacted] stated	F0812		02/02/2026

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F0812 SS = F	Continued from page 3 that "the stove is old and the lining is old and anything that drips sticks to it." 7.The surveyor observed black crusted substances located in the bottom corners of the oven that were easily lifted with the tip of the surveyor's pen. 8.The surveyor observed two of two frying pans with crusted black substance lining the entire pan on both pans. Follow-Up Kitchen Tour on 1/22/26: 9.The surveyor observed an additional frying pan containing crusted black substance around the perimeter of the pan on the inside and outside with caked black substance on the area where the handle and the pan meet. This was identified in front of the [redacted] and she acknowledged the concern and stated she would "get rid of the pan". 10.The surveyor observed no trash bin at the second hand washing station to dispose of paper towels. This concern was addressed with the [redacted] and she stated, "the hand washing station should have a small trash bin to throw away paper towels. Maybe it got moved last night when they were cleaning them". A review of the facility's "Dry Food Storage Policy" which requires that unacceptable, dented canned good will be reported and returned/discarded promptly... A review of the facility's "Food Storage Policy" which requires that all foods are securely covered, dated, and labeled... A review of the facility's "Kitchen cleaning policy" which requires that staff shall maintain the sanitation of the kitchen... During an interview on 1/22/26 at 02:00 PM, the surveyor brought the above concerns to the attention of the [redacted]	F0812		02/02/2026

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F0812 SS = F	Continued from page 4 On 1/29/26 at 1:50 PM, the survey team met with the[redacted] for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-17.2(g)	F0812		02/02/2026
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and	F0838	All residents were affected by this deficient practice. At the time of notification facility assessment was updated by the facility administrator to reflect the changes of the updated regulatory requirements. All residents have the potential to be affected by this deficient practice. [redacted] educated by Regional Nurse regarding updated regulations regarding facility assessment. Administrator educated all staff on updates to facility assessment. Administrator / designee will review facility assessment to ensure compliance and following of regulatory requirements monthly x 3 months. Results of the audits will presented at the quarterly QAPI meetings. Date of Completion: 01/29/2026	02/02/2026

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F0838 SS = F	Continued from page 5 nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members.	F0838		02/02/2026

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F0838 SS = F	Continued from page 6 §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3). §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and review of pertinent documentation, it was determined that the facility failed to ensure the facility-wide assessment was revised and included the contingency plan that address the facility's need with regard to staffing. This failure had the potential to affect all 117 residents who currently live in the facility. This deficient practice was evidenced by the following: According to the CMS (Centers for Medicare & Medicaid Services) Ref: QSO-24-13-NH, dated 6/18/24, Subject: Revised Guidance for Long-Term Care Facility Assessment Requirements, Memorandum Summary: • Under the "Minimum Staffing Standards for	F0838		02/02/2026

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F0838 SS = F	Continued from page 7 Long-Term Care (LTC) Facilities and Medicaid Institutional Payment Transparency Reporting" final rule, the requirements for Facility Assessment have been revised… These new provisions become effective 90 days after publication and must be implemented by 8/8/24… §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3)… §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. On 1/21/26 at 9:50 AM, the surveyor met with the U. S. FOIA (b) (2)) and the U. S. FOIA (b) (2)) an entrance conference. The stated that the current census was 117 (total number of residents). The surveyor requested from the U. S. FOIA (b) (2) a copy of the most updated Facility Assessment (FA). On that same date and time, the U. S. FOIA (b) confirmed that the facility did not utilize agency staff for staffing needs for nursing. The U.S. FOIA (b) further stated that the facility was not on a NJ Ex Order 26.4(b)(1) A review of the provided FA, with an approved date of 7/29/25, that was provided by the U. S. FOIA (b), revealed that the FA will be reviewed and updated, as necessary, and at least annually. Whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment, the Administrator will ensure that all relevant elements of the assessment is reviewed and updated...Contingency Planning for Staffing: "In the case of an emergent event, the facility's emergency plan will be activated. If the event does not rise to the level of activation of the facility's emergency plan the facility will: Refer to COVID contingency staffing pattern/plan."	F0838		02/02/2026

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F0838 SS = F	Continued from page 8 On 1/29/26 at 10:29 AM, the surveyor met with the [U.S. FOIA (b)] and [U.S. FOIA] for QAPI (Quality Assurance Performance Improvement) meeting. The [U.S. FOIA (b)] confirmed the provided 7/29/25 FA was the most updated one. The [NJ Ex Order] stated that the FA was reviewed and updated quarterly, during the facility's QAPI meeting, annually, and as needed if there would be a global change identified by CMS. The surveyor asked the [NJ Ex Order] and [NJ Ex Ord] if they were aware of the updated regulatory requirements with minimum staffing of the CMS, and there was no response. On that same date and time, the surveyor asked the [U.S. FOIA (b)] as to why the update regulatory requirement from the CMS effective 8/28/24, with regard to contingency plan was not followed in their FA, and the [U.S. FOIA (b)] did not respond. On 1/29/26 at 1:50 PM, the survey team met with the [U.S. FOIA (b)(6)], and [U.S. FOIA (b)(6)] for exit conference, and there was no additional information provided by the [U.S. FOIA (b)] NJAC 8:39-33.2(b)(c)(13)(d); 34.1(a)	F0838		02/02/2026
F0584 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 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	F0584	No residents were affected by this deficient practice. Upon notification temperature was adjusted in the [NJ Ex O] floor dining area and the [NJ Ex O] floor dining area. The tables in the [NJ Ex O] floor dining area had the laminate repaired. The pipe in room [NJ Ex Oth] was addressed, linen cart covers were replaced and infection preventionist ensured staff was educated to ensure they remained covered. The curtains in room [NJ Ex Oth] and [NJ Ex Oth] were fixed and the vent was cleaned. The rug and wallpaper on the [NJ Ex O] floor were addressed and the wallpaper on the [NJ E] h floor was addressed. All residents have the potential to be affected by this deficient practice. All common areas checked by maintenance and addressed for temperature. All linen carts inspected to ensure clean and closed, all rooms audited to ensure curtains were hanging appropriately by U. S. FOIA (b) (2). Rugs and wallpaper was addressed on all floors for cleanliness and repair by U. S. FOIA (b) (2). In servicing done by administrator with	02/02/2026

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F0584 SS = E	Continued from page 9 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: Complaint NJ#384180 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide a safe, clean, and comfortable homelike setting. This deficient practice was identified for 4 of 4 units and common areas, and was evidenced by the following: The deficient practice was evidenced by the following: 1.On 1/21/26 at 10:31 AM, during the initial tour of the facility, Surveyor #1 (S #1) entered the [redacted] floor dining/activity area and observed the wall mounted thermostat. The thermostat indicated a temperature (temp) of 67 degrees Fahrenheit (deg F). On that same day, at 10:50 AM, S #1 entered the [redacted] floor dining/activity area and observed seven square tables in the room, 4 of the 7 tables were observed to have the thin laminate surface peeling back leaving a sharp edge and a wood surface underneath.	F0584	Continued from page 9 U. S. FOIA (b) (2) regarding policies titled maintenance regarding ensuring safe and home like environment, comfortable and safe temperature levels. Administrator / designee will conduct an audit weekly x 4 weeks and then monthly x 2 months to ensure temps in all common areas are within regulation, 5 rooms will be audited to ensure curtains are hanging appropriately, all dining rooms will be checked to ensure table laminate is not lifting, 5 rooms will be checked to ensure pipe covers are attached, 5 linen carts will be audited to ensure the covers are cleaned and down, and 2 floors will be rounded on to ensure no carpet stains or peeling wallpaper is observed. Results of the audits will be discussed at the monthly quality assurance performance improvement meetings. Date of Completion: 01/23/2026	02/02/2026

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F0584 SS = E	Continued from page 10 On 1/27/26 at 11:28 AM, S #1 entered the [NJ Ex 7C] floor dining/activity room and observed the wall mounted thermostat and indicated a temp of 66.7 def F. On 1/28/26 at 12:33 PM, the facility [U. S. FOIA (b) (2)] provided to the survey team, documents "Environmental Temp and Safety Rounds". S #1 reviewed the documents and did not reflect any temp measurements of the dining/activity areas on any of the facility floors. On 1/28/26 at 1:47 PM the survey team met with the [U. S. FOIA (b) (2)], and S #1 notified them of the above concerns. On 1/29/26 at 11:44 AM, the survey team met with the [U. S. FOIA (b) (2)] for responses to above concerns. The [U. S. FOIA (b)] stated that the building was acquired approximately 2 ½ years prior and infrastructure improvements were made. The [U. S. FOIA (b)] stated that there were unseasonable temp, and it was exceptionally cold with temp in the 10 to 20 degrees F range. The [U. S. FOIA (b)] stated that there was a new statute in New Jersey for Long Term Care Facilities that gave different temp regarding air conditioning and heating and that was what they were following. The [U. S. FOIA (b)] stated that the [NJ Ex 7C] Floor dining area was not being used and was "decommissioned". On that same date and time, Surveyor #2 (S #2) stated that there were no notifications on the doors of the dining area that was not being used, or anywhere else in the facility and the doors were able to be opened. S #2 further stated that there were no notifications either to the survey team, visitors, residents, and staff that the dining room was "decommissioned", and if they were, should there be a prior notifications, and the [U. S. FOIA (b)] did not respond. The [U. S. FOIA (b)] did not provide any further pertinent information. A review of the memorandum from the Executive Director Division of Certificate of Need and Licensing, dated [NJ Ex Order 283] that was provided by the [U. S. FOIA (b)], Re: Statutory Amendments Regarding Temperature Level Standards Pursuant to NJSA	F0584		02/02/2026

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 01/29/2026

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F0584 SS = E	Continued from page 11 26:2H-14.13 et seq. The memorandum reflected: In addition, the ACT requires facilities to not have the temperature in areas used by residents fall below 65 degrees Fahrenheit...Where the Centers for Medicare and Medicaid Services (CMS) has a temperature range set by regulation that differs from the standards set in the Act, a nursing home…licensed by the Department of Health may follow the temperature levels set by CMS... 2. On 1/23/26 at 8:47 AM, Surveyor #2 (S #2) with Certified Nursing Aide #1 (CNA #1) went inside Room [NJ Ex Order 26, 4B1] and observed there was a white pipe that was on the floor. CNA #1 stated that it was probably from the sink metal part cover of under. 3. On 1/23/26 at 8:40 AM, S #2 went to [NJ Ex] floor unit and observed in the hallway, near Room [NJ Ex O] [NJ Ex Order 25] a linen cart not fully covered. The top cover of the linen cart with whitish, blackish dried substances and with brownish stain on the side of cover. At that time, S #2 observed the [U. S. FOIA (b) (2)] in the hallway. S #2 notified the [U. S. F] of the above concerns with the linen cart, and she stated that the linen cart should not be left open. Certified Nursing Aide #2 (CNA #2), in the presence of the [U. S. FO], informed S #2 that the white stain on top of the linen cart cover were from the soap that burst. 4. On 1/23/26 at 9:04 AM, S #2 with the [NJ Ex O] floor [U. S. FOIA (b) (2)] went to Room [NJ Ex Order] ([NJ Ex Order 25]) and both observed the privacy curtain was hanging and not properly hooked on the rods. The [U. S. FOIA (b)] stated that she would ask someone to fix it. On 1/23/26 at 9:12 AM, S #2 and the [U. S. FOIA (b)] went to Room [NJ Ex Order 26, 4B1]), and both observed the privacy curtain was hanging and not properly hooked on the rods. S #2 also observed the ceiling vent with accumulation of grayish substances, that was upon entry to [NJ Ex Order 2] 5. On 1/28/26 at 12:20 PM, S #2 [U. S. FOIA (b) (2)] went to the [NJ Ex O] floor. S #2 asked the [U. S. FOIA (b) (2)] to check the temp inside the [NJ Ex O] floor dining room, and it was 64	F0584		02/02/2026

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F0584 SS = E	Continued from page 12 degrees. The [NJ Ex O] floor dining room and hallway was cold. The U. S. FOIA (b) (2) acknowledged that the dining room and the hallway were considered common areas for the residents, and temp should be between 68 to 81 degrees. On 1/28/26 at 1:47 PM, the survey team met with the U. S. FOIA (b) (2), and S #2 notified them of the above findings and concerns with [NJ Ex Order 26, 4B1], and [NJ Ex Order 26]. S #2 also notified the U. S. FOIA (b) (2) of the laundry room concerns and temperature concern in the [NJ Ex O] floor areas. On 1/29/26 at 11:43 AM, the survey team met with the U. S. FOIA (b) (2). The surveyor then asked if residents should have homelike environment as part of requirement, and the [U. S. FOIA (b)] responded yes. On that same date and time, the [U. S. FOIA (b)] informed the surveyors that the heating guidance for temp of the building should not exceed 81 degrees and not below 65 degrees. S #2 then notified the [U. S. FOIA (b)] again of the concern that on 1/27/26, the temperature in the [NJ Ex O] floor dining room was 64 degrees. 6. On 1/22/26 at 10:35 AM, Surveyor #3 (S #3) observed on the [NJ Ex O] floor between Rooms [NJ Ex Order 26, 4B] the rug on the hallway stained with large, dark, brownish substance, handrails scuffed and with wear, and wall stained with brown substances. S #3 observed by Room [NJ Ex Order 26, 4B1]) hallway with the wallpaper peeling. S #3 observed [NJ Ex O] floor hallways throughout some areas with dark stains on the rug, including the rug around the nursing station. S #3 observed the rug and walls around Rooms [NJ Ex Order 26, 4] stained throughout some spots. S #3 observed the [NJ Ex O] floor dining room area with peeling wallpaper. On 1/22/26 at 10:53 AM, S #3 in the presence of the [NJ Ex O] floor [U. S. FOIA (b)] observed the stained rugs and walls and she confirmed that she addressed the concerns with the U. S. FOIA (b) (2) every time "I get a new patient, I verbally expressed my dilemma in the morning meeting", and it had been "like that over a year", no matter how much "they" shampoo it did not come off. The [U. S. FOIA (b)] further stated "They tell me they know". On 1/22/26 at 11:09 AM, S #3 interviewed the U. S. FOIA (b) (2), and	F0584		02/02/2026

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F0584 SS = E	Continued from page 13 she stated that the rugs were 30 years old, even it was shampooed every two weeks, the floor stains did not come out. She further stated "I have to look at the peeled wallpaper. If we use bleach, it gets worse. I've been asking them to change the wallpaper". On 1/22/26 at 11:55 AM, S #3 observed the [redacted] floor main dining room with peeled wallpaper on the ceiling near the television and the walls. S #3 observed the rug area by the windows on the right side, stained with brownish substance. On 1/28/26 at 2:44 PM, the survey team met with the U. S. FOIA (b) (2), and S #3 notified them of the above concerns regarding the environment. A review of the facility's "Safe and Homelike Environment Policy", that was provided by the LNHA, with a reviewed date of 9/1/25, revealed under policy, in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment…This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Under definitions: "Comfortable and safe temp levels" means that the ambient temp should be in a relatively narrow range that minimizes residents' susceptibility to loss of body h eat and risk of hypothermia/hyperthermia and is comfortable for the residents. "Environment" refers to any environment in the facility that is frequented by residents, including the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas and activity areas. "Sanitary" includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in completion of the activities of daily living. On 1/29/26 at 1:50 PM, the survey team met with the U. S. FOIA (b) (2) [redacted] for exit conference, and there was no additional information provided by the [redacted].	F0584		02/02/2026

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F0584 SS = E	Continued from page 14 NJAC 8:39-31.2(e); 31.4(a)(b)(e)(f)	F0584		02/02/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F0880	No residents were affected by this deficient practice. Upon notification soap dispenser in room [redacted] was refilled, linen cart by room [redacted] was replaced and covered, the fan in the laundry room was removed from the laundry area, and the plastics and paper were removed from linen cart 2 and the laundry room was cleaned. Nurses immediately in serviced on hand hygiene after doffing personal protective equipment and when changing removing gloves. All residents have the potential to be affected by this deficient practice. An audit conducted by the Housekeeping Director of all soap dispensers, linen carts, and fans to ensure compliance. Education done with all staff regarding hand hygiene and the personal protective equipment policy by the infection preventionist. Education done by Infection Preventionist on the hand hygiene policy and personal protective equipment policy with all staff. Education done by Housekeeping Director regarding ensuring soap dispensers are not empty, linen cart covers remain clean and covered, and that the laundry room and fans remain clean and free of dust. Administrator / designee will conduct an audit of 10 soap dispensers to ensure they are not empty, 5 linen carts to ensure they remain covered and covers are clean and that there is no debris in the laundry area weekly x 4 weeks then monthly x 2 months. The Infection Preventionist will observe 5 staff members weekly x 4 weeks then monthly x 2 months to ensure staff is practicing appropriate hand hygiene after removal of personal protective equipment. The results of the audit will be presented at the monthly quality assurance performance improvement meetings. Date of Completion: 01/29/2026	02/02/2026

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F0880 SS = E	Continued from page 15 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. 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: REPEAT DEFICIENCY Based on observation, interview, and review of other pertinent facility documentation, it was determined that the facility failed to; a.) follow appropriate hand hygiene with regard to accessibility and availability of soap, for 1 of 5 resident rooms (Room [redacted] observed during tour, b.) ensure proper storage of linen supplies for 3 of 6 linen carts [redacted] and [redacted] floors and clean laundry room), c.) maintain cleanliness of the laundry room for 2 of 2 rooms (clean and dirty laundry rooms), d.) ensure the proper use of disinfecting wipes, and e.) follow appropriate infection control and sanitary practices for while donning and doffing personal protective equipment (PPE) for 2 of 2 nurses observed during the medication pass (med pass), in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene	F0880		02/02/2026

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F0880 SS = E	Continued from page 16 for Healthcare Workers, February 27, 2024, Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with: Handwashing with water and soap (e.g., plain soap or with an antiseptic)… According to CDC Appendix D - Linen and laundry management Best Practices for Environmental Cleaning in Global Healthcare Facilities with Limited Resources, Best Practices for Environmental Cleaning in Global Healthcare Setting, March 19, 2024. The Best practices for management of clean linen: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Each floor/ward should have a designated room for sorting and storing clean linens. Transport clean linens to patient care areas on designated carts or within designated containers that are regularly (e.g., at least once daily) cleaned with a neutral detergent and warm water solution. 1.On 1/22/26 at 8:58 AM, Surveyor #1 (S #1) observed Room [redacted] toilet room with no soap in the dispenser. On 1/23/26 at 8:24 AM, S #1 asked [redacted] to accompany S #1 inside [redacted] the resident was inside the room at that time. Both S #1 and the [redacted] observed [redacted] toilet room with empty soap dispenser. S #1 also notified the [redacted] of the concern that was observed yesterday (1/22/26) at 8:58 AM. The [redacted] informed S #1 it was the responsibility of the housekeeper to put soap and acknowledged that staff use the sink for handwashing and there should be soap in the dispenser. She further stated that she would notify the [redacted] On 1/23/26 at 8:35 AM, S #1 interviewed the [redacted] who informed S #1 that he was responsible for putting soap in the resident's room. S #1 notified the concern about [redacted] with no soap for two days, and he did not respond. 2. On 1/23/26 at 8:40 AM, S #1 went to [redacted] floor unit, observed in the hallway, near Room [redacted] a linen cart was not fully covered, with clean linen supplies	F0880		02/02/2026

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F0880 SS = E	Continued from page 17 inside. S #1 observed the top cover with whitish, blackish dried substances, and the side of the cover with brownish stain. At that time, S #1 observed the [U. S. FOIA (b) (2)] in the hallway. S #1 asked the [U. S. F] about the linen cart and notified the concern about leaving open and asked what those stains were. The [NJ Ex C] stated she was unsure what those stains were, and she stated that the linen cart should not be left open. Certified Nursing Aide #1 (CNA #1) came and informed S #1 and the [U. S. FO] that the white stain on top of the linen cart cover were from soap that burst. On 1/23/26 at 9:10 AM, S #1 with [U. S. FOIA (b) (2)] both observed the [NJ Ex C] floor linen cart cover had whitish substance stained on top of the cover, and as per CNA #2, who was at that time getting something from the linen cart stated that they did not know what the white on the linen cart cover was. 3. On 1/28/26 at 8:20 AM, S #1 went to the laundry room and toured with [U. S. FOIA (b) (2)] The [U. S. F] informed S #1 that the 1st room was considered the clean laundry room where the linen supplies and residents' clothes were dried, folded and stored in the four linen carts to be delivered later for 3 PM-11 PM shift. Both S #1 and the [U. S.] observed the big stand fan blowing air towards the clean linen supplies that were about to be folded and towards the table where there were folded linen supplies. The big stand fan with accumulation of grayish substances which the [U. S.] confirmed were accumulation of dust and should have been cleaned. The floor was observed with dust. At that same time, there were four linen carts, the 2nd linen cart was observed with papers and plastics on the bottom shelf, and there were clean linen supplies inside the cart. On that same date and time, both S #1 and the [U. S. FO] observed the next room, which the [U. S. FO] stated considered the dirty area of the laundry room where the linen supplies were being washed. There was an accumulation of grayish substances on the floor, walls, and washers. The [U. S. F] confirmed they were accumulation of dust and should have been cleaned. The [U. S. FO] also stated that there was no accountability log for cleaning the laundry rooms.	F0880		02/02/2026

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F0880 SS = E	Continued from page 18 On 1/28/26 at 12:35 PM, S #1 interviewed the U. S. FOIA (b) (2) who informed S #1 that she was responsible for service and competencies for all staff with regard to infection control and she does rounds daily in the residents' units, of resident's common area, rooms, and laundry. S #1 asked the [redacted] as to why it was important to ensure that there was soap in the dispenser inside the resident's room and toilet room, and the [redacted] responded that staff to wash hands properly and soap was needed. S #1 notified the concern with [redacted] with no soap for two days of observation. On that same date and time, S #1 notified the [redacted] of the concern in the laundry about the fan blowing air directly to clean uncovered linens supplies, the [redacted] stated the fan should be clean up. S #1 also notified the concern with linen carts in the laundry area with plastic and paper on the bottom of the linen cart with clean supplies and on [redacted] and [redacted] floors with stains on their linen cart covers and was left open. The [redacted] stated that "we" always clean the linen carts, it should be clean. On 1/28/26 at 1:47 PM, the survey team met with the U. S. FOIA (b) (2) [redacted], and the surveyor notified them of the above findings and concerns. A review of the facility's "Laundry Policy" that was provided by the [redacted] with a reviewed/revised date of 9/1/25, revealed, the facility launders linens and clothing in accordance with current CDC guidelines to prevent transmission of pathogens…Policy Explanation and Compliance Guidelines:…6. If using fans in laundry processing areas, prevent cross-contamination of clean linens from air blowing from soiled processing areas. On 1/29/26 at 11:43 AM, the survey team met with the U. S. FOIA (b) (2). The [redacted] stated that there was no additional information to provide. 4. On 1/23/26 at 8:44 AM, Surveyor #2 (S #2) observed the Licensed Practical Nurse #1 (LPN #1) on the [redacted] floor for med pass. S #2 observed LPN #1 donned (put) PPE, gloves and a gown, to enter a resident's room to administer medications (meds). S #2 observed a signage outside of the room reflected	F0880		02/02/2026

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F0880 SS = E	Continued from page 19 that the resident had NJ Ex Order 26.4(b)(1) [redacted] S #2 observed LPN #1 administer meds, remove (doffed off) the gown and gloves into a receptacle then proceeded to the med cart. S #2 did not observe LPN #1 perform hand hygiene after removal of PPE. On the same date, between the times of 9:05 AM and 10:10 AM, S #2 observed LPN #2 on the [redacted] floor for med pass. S #2 observed LPN #2 performed the following tasks while administering meds to several residents who had [redacted] signage outside of their rooms. S #2 observed LPN #2 donned and and doffed off PPE after cleaning the cuff of the facility electronic blood pressure machine (BP cuff) and not perform any hand hygiene. S #2 observed LPN #2 changed gloves several times after leaving a resident's room and in between cleaning the BP cuff and not perform hand hygiene. S #2 observed LPN #2 cleaned the BP cuff with a cleaning wipe obtained from a purple top container and not waited the required contact time of two minutes as reflected on the front label of the container before using the BP cuff on the next resident. S #2 observed LPN#2 cleaned the BP cuff right before using on a resident and observed LPN #2 cleaned the BP cuff right after another resident. On 1/28/26 at 12:47 PM, S #2 interviewed the [redacted] and asked the [redacted] if the staff was provided with education on infection control procedures, including but not limited to use of PPE, hand sanitizing procedures, and cleaning of medical equipment. The [redacted] stated yes, the staff were made aware via education of these policies and procedures. S #2 asked what was expected for a staff member who was entering a room marked EBP but not having direct care. The [redacted] stated the staff would be expected to sanitize hands by washing or alcohol gel before and after, PPE was only needed for direct care. The [redacted] further stated hand sanitizing before and after. At that same time, S #2 asked what the procedure was with used for cleaning medical equipment. The [redacted] stated that the "purple top" wipes should be used, with gloves, the staff should wait at least two minutes before using again per the product instructions. She also stated that the staff should follow hand sanitizing when removing gloves after cleaning. The [redacted] added that the equipment should be sanitized after use and before moving on to the	F0880		02/02/2026

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 01/29/2026

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

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F0880 SS = E	Continued from page 20 next resident and if the staff was using equipment and they were unsure it had been cleaned, they should clean it. On 1/28/26 at 1:47 PM, the survey team met with the[U. S. FOIA (b) (2)] and S #2 notified them of the above findings and concerns during medpass. On 1/29/26 at 11:44 AM, the survey team met with the[U. S. FOIA (b) (2)] for responses to concerns. The [U. S. FOIA] stated that the nurses in question may have been nervous during the observation. The [U. S. FOIA] also stated that an educational in-service was done for the whole building on 1/28/26. A review of the facility's "Hand Hygiene Policy" that was provided by the [U.S. FOIA (b)] with a reviewed/revised date of 9/1/25, revealed, all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors…"Hand hygiene" is a general term for cleaning hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR)…Policy Explanation and Compliance Guidelines:..5. Hand Hygiene technique when using soap and water: a. Wet hands with water…b. Apply to hands the amount of soap recommended by the manufacturer…6.a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The policy also revealed a Hand Hygiene Table. The table reflected a box checked to use either soap and water or alcohol-based hand rub (preferred) next to "Before applying and after removing PPE, including gloves". A review of the facility's "Cleaning and Disinfection of Resident-Care Equipment Policy", with last reviewed/revised date of 9/1/25, the policy reflected under 3.b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. 3.j. Follow manufacturer recommendations for cleaning equipment. A review of the facility's "Personal Protective Equipment Policy", last reviewed/revised date of 9/1/25, the policy reflected, under 5.b. …Perform	F0880		02/02/2026

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F0880 SS = E	Continued from page 21 hand hygiene after removing gown… The [U. S. FOIA] did not provide any further pertinent information. NJAC 8:39-19.4 (a)1., (l); 19.4(a)(2)	F0880		02/02/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.	F0605	Resident #12 was affected by this deficient practice. Resident 12 was no longer in the facility at the time of notification. All residents on as needed (PRN) psychotropic medication have the potential to be affected by this deficient practice. All residents on PRN psychotropic medication reviewed to ensure 14 day stop dates where in place and/or rationale for continued use was documented in the medical record. Director of Nursing / Designee educated nurses on ensuring all PRN psychotropic medication have a 14 day stop date or if continued past 14 days a documented rationale for use. Director of Nursing / Designee will audit 5 residents on PRN psychotropics to ensure stop date is implemented weekly x 4 weeks and then monthly x 2 months. Results of the audits will be discussed at the quarterly QAPI meetings.	02/02/2026

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 01/29/2026

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F0605 SS = D	Continued from page 22 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that	F0605		02/02/2026

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F0605 SS = D	Continued from page 23 medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to ensure as needed [NJ Ex Order 26.4(b)(1)] medication ordered was limited to 14 days, unless the attending physician/prescribing practitioner documents a rationale to extend the medication for 1 of 5 residents reviewed for unnecessary medications (Residents #12). This deficient practice was evidenced by the following: On 1/21/26 at 10:44 AM, the surveyor observed Resident #12 lying asleep in bed. A review of Resident #12's Admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: [NJ Ex Order 26, 4B1] [redacted] A review of Resident #12's most recent Annual Minimum Data Set (MDS) reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Ex Order 26, 4B1] which indicated the resident's [NJ Ex Order 26, 4B1] [redacted]. A review of Resident #12's [NJ Ex Order 26, 4B1] electronic Medication Administration Record (eMAR) and	F0605		02/02/2026

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F0605 SS = D	Continued from page 24 electronic Treatment Administration Record (eTAR) included the following orders: NJ Ex Order 26, 4B1 [redacted] with an order date of [redacted]. The order was not limited to 14 days. A review of Resident #12's Progress Notes did not include any documentation from the attending physician/prescribing practitioner, a rationale to extend the medication (med). On 1/23/26 at 12:23 PM, the surveyor interviewed the U. S. FOIA (b) (2) [redacted]) who stated that when a resident received NJ Ex Order 26, 4B1 there was an order for [redacted] PRN but was not sure if it required a 14 day stop to be reevaluated if a resident needed it. On 1/27/26 at 11:26 AM, the surveyor interviewed the U. S. FOIA (b) (2) [redacted] who stated that the NJ Ex Order 26, 4B1 for Resident #12 should have had a stop date. On 1/27/26 at 1:55 PM, the surveyor notified the U. S. FOIA (b) (2) [redacted] the concern that Resident #12's [redacted] order was not limited to [redacted] days and that there was no documentation of a rationale to extend the med. On 1/28/26 at 1:50 PM, the surveyor met with the U. S. FOIA (b) (2) to provide an opportunity for a response for the concern. The [redacted] did not provide any additional information. N.J.A.C. 8:39-27.1	F0605		02/02/2026
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each	F0640	1. Residents 51 and 94 were affected by this deficient practice. Upon notification MDS staff was educated on timing of assessments and ensuring MDSs are submitted timely 2. All residents have the potential to be affected by this deficient practice. All residents audited to ensure MDSs were submitted timely.	02/02/2026

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F0640 SS = D	Continued from page 25 resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the	F0640	Continued from page 25 3. Regional MDS educated facility U. S. FOIA (b) (2) regarding timely submission. 4. Regional MDS / designee will conduct an audit of 5 MDSs weekly x 4 weeks then monthly x 2 months to ensure timely completion and submission of MDSs. The results of the audit will be presented at the monthly quality assurance performance improvement meetings. Date of Completion: 01/292026	02/02/2026

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F0640 SS = D	Continued from page 26 format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, it was determined that the facility failed to complete the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within fourteen days as required, for 2 of 31 residents, (Residents #51 and #94), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following: The surveyor reviewed the medical records of the following residents and their MDS and revealed: 1. On 1/27/26 at 1:35 PM, the surveyor reviewed Resident #51's comprehensive Admission MDS dated [NJ Ex Order 26.4], which revealed it was completed late on [NJ Ex Order 26.4] (3 days late). The resident had an Entry MDS which was dated [NJ Ex Order 26.4] 2. On 1/27/26 at 1:38 PM, the surveyor reviewed Resident #94's comprehensive Admission MDS dated [NJ Ex Order 26.4], which revealed it was completed late on [NJ Ex Order 26.4(b)(1)] late). The resident had an Entry MDS which was dated [NJ Ex Order 26.4(b)] On 1/28/26 at 11:38 AM, the surveyor interviewed the [U. S. FOIA (b) (2)]) who stated that she was responsible for MDS assessments, "We try to do the assessments as they are due". The [U. S. FOIA (b)] further stated that "We" follow the Resident Assessment Instrument (RAI-a comprehensive assessment and care plan process). The surveyor asked when the Admission MDS should be completed. The [U. S. FOIA] replied that the assessment and the Care Areas (CAAS) need to be completed on the 14th day from admission. The surveyor and the [U. S. FOIA] reviewed Resident #51's and Resident #94's comprehensive [U. S. FOIA (b) (2)] confirmed regarding Resident #51's Section F-activities was done late. She also stated that it should have been completed it on time. At that same time, the [U. S. FOIA (b)] stated for Resident #94, "It was the Care Areas that were late, it should have been completed earlier". The surveyor requested validation reports (CMS Submission Report) for the two comprehensive MDS assessments.	F0640		02/02/2026

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F0640 SS = D	Continued from page 27 On 1/28/26 at 2:00 PM, the U. S. FOIA (b) (2) provided the validation reports (CMS report) which confirmed Resident #51's Admission MDS assessment dated NJ Ex Order 26 was completed late including the Care Areas/Care Plan. Resident #94's Admission MDS dated NJ Ex Order 26, 49 also reflected as completed late due to the Care Areas/Care Plan not being completed timely. On 1/28/26 at 2:32 PM, the survey team met with the U. S. FOIA (b) (2) and the surveyor notified them of the concern with late MDSs completion. On 1/29/26 at 11:45 AM, the U. S. FOIA (b) did not provide additional information. A review of the facility's "MDS 3.0 Completion Policy" dated 9/1/25, revealed under Policy Explanation and Compliance Guidelines 2b, Admission Assessment- completed within 14 days of admission counting the day of admission as day #1. NJAC 8:39-11.1, 11.2(e)	F0640		02/02/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641	Resident 3 and 67 were affected by this deficient practice. Upon notification the MDS was corrected and education was done with the U. S. FOIA (b) (2) for accurate coding. All residents have the potential to be affected by this deficient practice. An audit of all MDS sections H0100, J0200-J0600 and M0100-M0300 by the MDS Director or designee and any discrepancies were corrected. Education by Regional MDS was done with U. S. FOIA U. S. FOIA (b) (2) to ensure accurate coding. Regional MDS will conduct an audit of 5 charts for MDS sections H0100, J0200-J0600 and M0100-M0300 to ensure accuracy weekly x 4 weeks and then monthly x 2 months. The results of the audits will be presented at the monthly Quality Assurance Performance Improvement meetings.	02/02/2026

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F0641 SS = D	Continued from page 28 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately reflect the resident status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care in accordance with the federal guidelines for 2 of 31 residents (Residents #3 and #67) reviewed for the accuracy of MDS coding. This deficient practice was evidenced by the following: A review of the Centers for Medicare & Medicaid Services (CMS's) Resident Assessment Instrument (RAI; helps facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan) Version 3.0 Manual, October 2025, reflected under Section M Skin Conditions, Steps for Assessment 1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and NJ Ex Order 26, 4B1 assessments. 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. 3. Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present. Assess key areas for NJ Ex Order 26, 4B1 development (e NJ Ex Order 26, 4B1 [redacted] . Also assess NJ Ex Order 26, [redacted] … 1.Surveyor #1 (S #1) reviewed the electronic medical	F0641	Continued from page 28 Date of Completion: 01/29/2026	02/02/2026

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F0641 SS = D	Continued from page 29 record (EMR) of Resident #3. A review of the Admission Record (AR; admission summary) reflected that Resident #3 was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, 4B1 [redacted] A review of the quarterly MDS with an assessment reference date (ARD) of [redacted] revealed in Section C, a Brief Interview for Mental Status (BIMS) [redacted] which reflected that Resident #3's cognition was unable to be assessed as the resident could not complete the interview. Section H, [redacted], revealed H0100 Appliances A that the resident was assessed as having an [redacted] H0300 NJ Ex Order 26, 4B1 indicated [redacted] not rated, as the resident was assessed as having a [redacted] A review of the resident's Progress Notes (PN) revealed a Physician's Note on [redacted], reflected, Pt (patient) was seen and examined for follow up. Pt saw [redacted], NJ Ex Order 26, 4B1 and pt [redacted]. The PN also revealed a General Note on [redacted] reflected a Note Text: received resident in bed alert but non verbal. resident voiding freely NJ Ex Order 26, 4B1 v/s (vital signs) stable no s/s (signs/symptoms) o [redacted] Entered by a U. S. FOIA (b) (2) [redacted] A review of the resident's Comprehensive Care Plan (CCP) dated [redacted], did not reflect that the resident had a NJ Ex Order 26, 4B1 was removed, or that the resident was NJ Ex Order 26, 4B1 On 1/22/26 at 11:50 AM, S #1 interviewed the U. S. FOIA (b) (2) on the floor where Resident #3 resides. The [redacted] stated that the NJ Ex Order 26, 4B1 was removed about two months ago due to [redacted] and now the resident voids and was [redacted] On 1/23/26, S #1 asked the U. S. FOIA (b) (2) [redacted] if the facility had a policy for MDS accuracy. The [redacted] stated that the facility followed the Resident Assessment Instrument (RAI)	F0641		02/02/2026

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 01/29/2026

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

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F0641 SS = D	Continued from page 30 manual. On 1/28/26 at 1:47 PM, the survey team met with the U. S. FOIA (b) (2)), and S #1 notified the U. S. FOIA (of the concern with the accuracy of Resident #3's MDS. On 1/29/26 at 11:44 AM, the survey team met with the U. S. FOIA (b) (2) for responses to concerns. The provided a CCP for Resident #3 that included a focus reflecting that the resident had NJ Ex Order 26, 4B1 dated NJ Ex Order 26, after surveyor inquiry. The did not provide any further pertinent information. 2. On 1/22/26 at 10:54 AM, Surveyor #2 (S #2) interviewed the U. S. FOIA (b) (2) and MDS Coordinator #1 (MDSC #1) regarding MDS. The U.S. FOIA (b) informed S #2 that both of them (MDSC #1) shared responsibilities with MDS and that they follow RAI Manual when doing MDS that included assessment, scheduling, completing and transmitting MDS. S #2 reviewed the medical records of Resident #67, and revealed: A review of the AR or face sheet revealed that Resident #67 was admitted to the facility with diagnoses that included but were not limited to; encounter for NJ Ex Order 26, 4B1 A review of the most recent comprehensive MDS, with an ARD of NJ Ex Order 26, reflected that Resident #67 had a BIMS score of NJ Ex Order 26, 4B1, indicated NJ Ex Orde Section J Health Conditions, reflected that the resident's NJ Ex Or assessment was signed off as completed on NJ Ex Order 26, 4B1 by MDSC #2. Section NJ Ex Order 26.4(b)(1) revealed that Resident #67 had NJ Ex Order 26, 4B1 A review of the active CCP did not reflect that the resident had an NJ Ex Order 26, 4B1. A review of the "Weekly NJ Ex Or Review" dated	F0641		02/02/2026

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F0641 SS = D	Continued from page 31 NJ Ex Order 26.4 revealed, Resident #67 had NJ Ex Order 26.4(b)(1) The NJ Ex Order 26, 4B1 were located in the NJ Ex Order 26, 4B1 There was no documented evidence that the resident had NJ Ex Order 26, 4B1. A review of the NJ Ex Order 26.4(b)(1) electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) revealed the order for NJ Ex Order 26, 4B1 discontinued (d/c) on NJ Ex Order 26. There were orders for NJ Ex Order 26, 4B1. On 1/27/26 at 12:52 PM, S #2 interviewed the U. S. FOIA (b) in the presence of MDSC #1 regarding MDS of Resident #67 for ARD NJ Ex Order 26.4. The U. S. FOIA (b) informed S #2 that MDSC #2 was their previous remote MDS staff. She also stated that MDSC #2 worked 100% remote when doing MDS. She also stated that the NJ Ex O assessment in the MDS should be done within ARD and not after the ARD. The U. S. FOIA (b) stated that the MDS responses to Section were auto populated responses from previous assessment. The U. S. FOIA (b) also confirmed and stated that the MDS should reflect the resident's current condition at that time period of assessment or ARD. At that same time, S #2 notified the U. S. FOIA (b) and MDSC #1 of the above concerns that Resident #67's ARD of NJ Ex Order 26 Section NJ Ex assessment was done on NJ Ex Order 26 at 8:08 PM, and the Section NJ was coded had NJ Ex Order 26, 4B1 when the resident's weekly NJ Ex O assessment on NJ Ex Order 26 did not reflect NJ Ex Order 26, 4B1 except for NJ Ex Order 26 S #2 also notified the NJ Ex Order and MDSC #1 that there was no care plan for NJ Ex Order 26.2 the eMAR and eTAR revealed on NJ Ex Order 26, 4B1 NJ Ex Order 26.4(b)(1) treatment order was d/c on . The had no respond when asked why the MDS ARD NJ Ex Order 26 did not reflect the current condition of resident's NJ Ex Order 2 at that time and interview for NJ Ex O assessment was done after the ARD. On 1/27/26 at 2:38 PM, the U. S. FOIA (b) stated that the facility did not have a policy with regard to accuracy of MDS, the facility followed the RAI Manual. On 1/28/26 at 9:02 AM, S #2 called and interviewed MDSC #2 regarding Resident #67's MDS. MDSC #2 informed S#2 that the reason she electronically	F0641		02/02/2026

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F0641 SS = D	Continued from page 32 signed Section [redacted] after the ARD on [redacted], because MDS to be done after the ARD and that she used the auto populated responses from the electronic medical record which was done on [redacted]. S #2 then asked MDSC #2, if she did use the auto populated responses from the [redacted] assessment, why the responses were not exactly the same and some were changed, and she did not respond. On that same date and time, S #2 asked MDSC #2 as to why Section [redacted] was coded with [redacted] if there were no treatment orders and no CP, and she responded that she would get back to S #2. She confirmed that she utilized medical records of residents when doing MDS and she did not interview residents or staff because she was a remote MDS worker and not physically present at the facility. On 1/28/26 at 10:14 AM, S #2 interviewed the [redacted] and confirmed that there were no other paper documents or medical records for residents because everything was uploaded in the electronic medical record. The [redacted] also stated that it was expected for the nurse to obtain an order for [redacted] treatment if there was [redacted]. The [redacted] informed S #2 that the facility follow the RAI manual. S #2 notified the above concern with Section J and M of Resident #67's MDS, and the [redacted] stated that MDSC #2 should have followed the [redacted] assessment on [redacted] because they were not here to interview the resident and "just helping". At that same time, S #2 notified the [redacted] of the concern with section [redacted] and the [redacted] stated that Resident #67 had [redacted] because it was resolved. The [redacted] acknowledged that the [redacted] MDS was inaccurate because the resident had no NJ Ex Order 26, 4B1 On 1/28/26 at 12:59 PM, the [redacted] provided a copy of the resident's order audit report which showed that the resident's NJ Ex Order 26, 4B1. The [redacted] stated that there was a problem in accuracy of MDS because the resident had [redacted] and it was an error from the nurse part when the nurse documented there was a [redacted]. On 1/28/26 at 1:47 PM, the survey team met with the U. S. FOIA (b) (2), and S #2 notified them of the	F0641		02/02/2026

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F0641 SS = D	Continued from page 33 above findings and concerns with Resident #67's MDS. On 1/29/26 at 11:43 AM, the survey team met with the U. S. FOIA (b) (2). The U.S. FOIA (b) stated that there was an accuracy problem with MDS of Resident #67. On 1/29/26 at 1:50 PM, the survey team met with the U. S. FOIA (b) (2) for exit conference, and there was no additional information provided by the U. S. FOIA (b). NJAC 8:39-33.2(a)	F0641		02/02/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by:	F0657	Resident #3 was affected by this deficient practice. Upon notification care plan reviewed and updated. All residents have the potential to be affected by this deficient practice. Nurses in serviced by Assistant Director of Nursing regarding initiating and updating of care plans for residents who are incontinent. All care plans reviewed to ensure compliance. Assistant Director of Nursing educated nurse managers on ensuring care plans are updated to reflect if a resident is continent vs incontinent. Director of Nursing / Designee to conduct an audit of 5 residents weekly x 4 weeks to ensure residents' incontinence is care planned then monthly x 2 months. Results of the audits will be reviewed in the quarterly QAPI meetings.	02/02/2026

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F0657 SS = D	Continued from page 34 Based on observation, interview and record review, it was determined that the facility failed to update and revise the comprehensive care plan of a resident. This deficient practice was identified for 1 of 31 residents (Resident #3), reviewed for [redacted] 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 and 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 regimens 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." The surveyor reviewed the electronic medical record (EMR) of Resident #3. A review of the Admission Record (admission summary) reflected that Resident #3 was admitted to the facility with diagnoses that included but were not limited to [redacted] A review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of [redacted] revealed in Section [redacted] a Brief Interview for Mental Status (BIMS) score [redacted] which reflected that Resident #3's [redacted] resident [redacted]	F0657		02/02/2026

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F0657 SS = D	Continued from page 35 interview. Section [redacted] NJ Ex Order 26, 4B1, revealed [redacted] Appliances [redacted] that the resident was assessed as having an [redacted] NJ Ex Order 26, 4B1. [redacted] indicated [redacted] not rated, as the resident was assessed as having a [redacted]. A review of the resident's Progress Notes (PN) revealed a Physician's Note dated [redacted] reflected that the resident was seen and examined for follow up [redacted] NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1 and the residen[redacted] NJ Ex Order 26, 4B1. The PN also revealed a General Note dated [redacted], reflected a Note Text that the resident was received in bed alert bu[redacted] NJ Ex Order 26, 4B1, resident voiding freely [redacted] removed no complications noted. that was electronically signed by a [redacted] U. S. FOIA (b) (2). A review of the resident's Comprehensive Care Plan (CCP) dated [redacted], did not reflect that the resident had a [redacted] NJ Ex Order 26, 4B1 was removed, or that the resident was [redacted] NJ Ex Order 26, 4B1. On 1/22/26 at 11:50 AM, the surveyor interviewed the [redacted] U. S. FOIA (b) (2) on the floor where Resident #3 resides. The surveyor asked the [redacted] about Resident #3's [redacted] NJ Ex Order 26, 4B1. The [redacted] stated that the [redacted] NJ Ex Order 26, 4B1 was removed about two months ago [redacted] NJ Ex Order 26, 4B1 and now the resident [redacted] NJ Ex Order 26, 4B1. On 1/28/26 at 1:47 PM, the survey team met with the [redacted] U. S. FOIA (b) (2), and the surveyor notified the concern that the CCP did not reflect that the [redacted] NJ Ex Order 26.4(b)(1) was discontinued to reflect the current condition of the resident. The surveyor asked the [redacted] if the CCP should include documentation if the resident was [redacted] NJ Ex Order 26, 4B1. On 1/29/26 at 11:44 AM, the survey team met with the [redacted] U. S. FOIA (b) (2) for responses to concerns. The facility provided a CCP for Resident #3 that included a focus reflecting that the resident has [redacted] NJ Ex Order 26, 4B1 [redacted] dated [redacted], after surveyor's inquiry. The [redacted] did not provide any further pertinent information.	F0657		02/02/2026

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F0657 SS = D	Continued from page 36 NJAC 8:39-11.1, 11.2(h)(i)	F0657		02/02/2026
F0658 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 observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to a.) follow a physician's order for side effect monitoring and clarify a physician's order for a NJ Ex Order 26, 4B1 for 2 of 28 residents reviewed (Resident #7 and Resident #12) and b.) follow NJ Ex Order 26, 4B1 and documentation for 1 of 31 residents, Resident #51, according to the standard of clinical practice and facility's policies. This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 well being, and executing a medical regimens 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 with in 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."	F0658	Residents 7 and 12 were affected by this deficient practice ---upon notification NJ Ex Order 26, 4B1 protocol for when a NJ Ex Order 26, 4B1 was updated. Resident 12 was NJ Ex Order 26.4(b)(1) this deficient practice --- upon notification nurses in-serviced on documentation of side effect if side effect is noted. Resident 51 was NJ Ex Order 26.4(b)(1) this deficient practice and upon notification all residents reviewed to ensure there was no duplication of administration of NJ Ex Order 26, 4B1. All residents with an order for hypoglycemic protocol and the order for TB skin test have the potential to be affected by these deficient practices. Assistant Director of Nursing / designee educated nurses on hypoglycemic protocol for a patient who is not awake, documentation of specific side effects when documenting a side effect is observed and administration of TB skin test and scheduling of order. Director of Nursing / designee will conduct an audit of 5 residents with orders for hypoglycemic protocol, side effect monitoring and TB skin tests to ensure compliance with facility policy weekly x 4 weeks and then monthly x 2 months, results of the audits will be reviewed at the monthly quality assurance performance improvement meeting. Date of Completion: 01/29/2026	02/02/2026

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F0658 SS = D	Continued from page 37 1. On 1/21/26 at 11:12 AM, Surveyor #1 (S #1) observed Resident #7 sleeping in bed. A review of Resident #7's Admission Record face sheet (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of Resident #7's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's NJ Ex Order 26, 4B1 for daily decision making were NJ Ex Order 26, 4B1. A review of Resident #7's January electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) included the following orders: A) Anticoagulant Medication (med) Monitoring: Monitor for NJ Ex Order 26, 4B1, NJ Ex Order 26, 4B1 [redacted] "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes' and progress note (PN) findings. every shift. Further review included that nurses signed Y for monitored and none observed and other nurses signed N but did not indicate in the PN what the side effect was that was observed as indicated in the order. B) IF RESIDENT IS NOT ALERT/NOT ABLE TO SWALLOW as needed for NJ Ex Order 26, 4B1 EPISODE Give meal or snack within 1 hour. The order was not clarified with the physician since a meal or snack would not be able to be given to a resident that was not alert or NJ Ex Order 26, 4B1. On 1/28/26 at 2:27 PM, S #1 notified the U. S. FOIA (b) (2) [redacted] the concerns regarding Resident #7's side effect monitoring for NJ Ex Order 26, 4B1 order which was not followed and the NJ Ex Order 26, 4B1 order that was not clarified.	F0658		02/02/2026

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F0658 SS = D	Continued from page 38 On 1/29/26 at 11:43 AM, in the presence of the U.S. FOIA (b)(6) stated that she in serviced staff regarding the y and the n, and supporting documentation for side effects. 2. On 1/21/26 at 10:44 AM, S #1 observed Resident #12 lying asleep in bed. A review of Resident #12's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of Resident #12's most recent comprehensive MDS reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ Ex [redacted], which indicated the resident's NJ Ex Order 26, 4B [redacted] A review of Resident #12's NJ Ex Order 26.4 eMAR and eTAR included the following orders: A) Anticoagulant Med Monitoring: Monitor for NJ Ex Order 26, 4B1 [redacted] t "Y" if monitored and none of the above observed. "N" if monitored and any of the above was observed, select chart code "other/see nurses notes' and PN findings. check Last INR (stands for International Normalized Ratio, a standardized measure of how long it takes NJ Ex Order 26, 4B1) result every shift with an order date of NJ Ex Order 26.4(b)(1) Review of the MAR indicated INR and the nurses documented No or NA or Y in the row for INR. Anticonvulsant Med Use -Observe resident closely for significant side effects: NJ Ex Order 26, 4B1 [redacted] Attention: In use with other CNS (Central Nervous System) NJ Ex Order 26, 4B1 or resident who develop NJ Ex Order 26, 4B1. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift with an order date of NJ Ex Order 2 [redacted] The nurses documented a check mark in the eMAR. The nurses did not document a Y or N as indicated in the order.	F0658		02/02/2026

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F0658 SS = D	Continued from page 39 NJ Ex Order 26, 4B1 Med Use -Observe resident closely for significant side effects: NJ Ex Order 26, 4B1 [redacted] every shift with an order date of NJ Ex Order 26 The order did not contain how to document if a significant side effect (s/e) was observed. NJ Ex Order 26, 4B1 Med Use -Observe resident closely for significant s/e: NJ Ex Order 26, 4B1 [redacted] every shift with an order date of NJ Ex Order 26. The order did not contain how to document if a significant s/e was observed. A review of Resident #12's PN did not include any documentation of what s/e was observed for any of the documented "N"'s in the NJ Ex Order 26 eMAR and eTAR. B) IF RESIDENT IS NJ Ex Order 26, 4B1 as needed for NJ Ex Order 26, 4B1 Give NJ Ex Order 26, 4B1. The order was not clarified with the physician since a meal or snack would not be able to be given to a resident that was NJ Ex Order 26, 4B1. On 1/23/26 at 12:23 PM, S #1 interviewed Licensed Practical Nurse #1 (LPN #1) who stated that for s/e monitoring there was an order in the computer and that if one of the listed s/e were observed there should be a PN. LPN #1 stated that there were different orders for NJ Ex Order 26, 4B1 when a resident NJ Ex Order 26, 4B and when a resident NJ Ex Order 26, 4B1. LPN #1 stated that Resident #12's NJ Ex Order 26, 4B1 when NJ Ex Order 26, 4 was not correct and that she thought it was a typo mistake. On 1/27/26 at 11:26 AM, S #1 interviewed the NJ Ex O floor Unit Registered Nurse/Unit Manager #1 (RN/UM #1) who stated that the nurses understand differently	F0658		02/02/2026

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 01/29/2026

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

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F0658 SS = D	Continued from page 40 the s/e monitoring order and that some say yes it was observed, and some say no. RN/UM #1 stated that there should be a standard one. RN/UM #1 stated that for the NJ Ex Order 26, 4B1 would be for a resident that [redacted] On 1/27/26 at 1:55 PM, S #1 notified the U. S. FOIA (b) (2) the concerns that Resident #12's s/e monitoring for several medications (meds) were not standard with the same legend with yes or no and that when a nurse indicated there was a s/e observed that the nurse did not indicate what the s/e was that was observed in the PN; and the NJ Ex Order 26, 4B1 order was not clarified. On 1/28/26 at 1:50 PM, in the presence of the U. S. FOIA (b) (2) stated that Resident #12's NJ Ex Order 26, 4B1 order was from a template in the computer and that it should have been clarified. The U. S. FOIA stated that she in-serviced nurses to be more specific to documentation of s/e monitoring. A review of the facility's "Provision of Physician Ordered Services Policy" with a reviewed/revised date of 9/1/25, included the following: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. A review of the facility's "Medication Monitoring/Side Effects Policy" with a reviewed/revised date of 9/1/25, included the following: This facility takes a collaborative, systematic approach to med management, including the monitoring of meds for efficacy and adverse consequences…4. Licensed nurses, with periodic oversight by nurse managers, shall:…b. Adhere to facility policies and current standards of practice for administration and monitoring of medications…e. Perform routine medication reconciliations to verify accuracy of medication orders. 3. On 1/21/26 at 11:17 AM, Surveyor #2 (S #2) observed the Resident #51 sitting in a wheelchair, not able to answer questions. A review of the AR which revealed diagnoses that included but not limited to: NJ Ex Order 26, 4B1 [redacted]	F0658		02/02/2026

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F0658 SS = D	Continued from page 41 NJ Ex Order 26, 4B1 A review of the comprehensive MDS, with an ARD of NJ Ex Order 26, 4B1 reflected BIMS score of NJ Ex Order 26, 4B1 indicating NJ Ex Order 26, 4B1 . A review of the physician's order (PO) dated 1/6/26, NJ Ex Order 26, 4B1, which is a NJ Ex Order 26, 4B1 used in the NJ Ex Order 26, 4B1 to determine if a person has been NJ Ex Order 26, 4B1) everyday shift for TB Screening for 1 administration until finished Step 1-Administer 0.1ml; A PO dated NJ Ex Order 26, 4B1 ..... Step 2-NJ Ex Order 26, 4B1 units after NJ Ex Order 26, 4B1 administration. Administer only if NJ Ex Order 26, 4B1 dose administration with a NJ Ex Order 26, 4B1 A review of the NJ Ex Order 26, 4B1 eMAR of the above PPD order entry dated , revealed the entry was NJ Ex Order 26, 4B1 signed by two different nurses to indicate the NJ Ex Order 26, 4B1 was administered to Resident #51 on NJ Ex Order 26, 4B1 by LPN #2 and NJ Ex Order 26, 4B1 by LPN#3. The NJ Ex Order 26, 4B1 results were read by LPN #2 on NJ Ex Order 26.4(b)(1) indicating NJ Ex Order 26, 4B1 . On 1/23/26 at 10:50 AM, S #2 reviewed with the NJ Ex Order 26, 4B1 floor Registered Nurse/Unit Manager #2 (RN/UM #2) regarding the concern on the eMAR the double administration of PPD given on NJ Ex Order 26.4(b)(1) UM/RN #2 stated, "The NJ Ex Order 26, 4B1 looks like it was given twice", and she did not know what happened, and she would look into it. A review of the PN revealed there was no documented evidence to indicate if the NJ Ex Order 26, 4B1 was administered or not administered to Resident #51 on NJ Ex Order 26, 4B1 . On 1/27/26 at 12:07 PM, S #2 interviewed LPN#2 with regard to facility's process for NJ Ex Order 26, 4B1 administration for new admissions and she stated that "We have to check" the PO for NJ Ex Order 26, 4B1 and administer upon admission, read after 72 hours, if negative, document it, and administer the 2nd dose	F0658		02/02/2026

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F0658 SS = D	Continued from page 42 of [NJ Ex Ord] in 14 days. LPN #2 further stated that she did not know why the [NJ Ex Ord] was administered twice. The LPN#2 confirmed it should have been given one time on admission only. On 1/27/26 at 12:15 PM, S #2 interviewed RN/UM #2 who stated the [U. S. FOIA] had spoken with LPN #3 and got a statement that it was a mistake on LPN #3's part. RN/UM #2 confirmed that it was after surveyor's inquiry. RN/UM #2 also stated that it was supposed to be documented if there was a mistaken entry. On 1/27/26 at 12:56 PM, the [U. S. FOIA] stated that LPN#3 informed the [U. S. FOIA] that he never administered the [NJ Ex Ord] (the duplicate), and for some reason "it popped up in the eMAR". The [U. S. FOIA] further stated, "We had a glitch of the computers at that time". The [U. S. FOIA] confirmed that there was no documented evidence that the duplicate [NJ Ex Ord] was an error and there was a computer error not until after surveyor's inquiry. On 1/28/26 at 2:36 PM, the survey team met with the [U. S. FOIA (b) (2)], and S #2 notified them of the above findings and concerns with regard to [NJ Ex Ord]. On 1/29/26 at 11:45 AM, the [U. S. FOIA (b) (2)] did not provide additional information. A review of the facility's "Administration and Interpretation of Tuberculin Skin Tests Policy" dated 9/1/25, revealed under Policy Explanation and Compliance Guidelines #2, skin testing of residents will be in accordance with physician orders... A review of the facility's "Provision of Physician Ordered Services Policy" dated 9/1/25, revealed under Definition, Professional Standards of Quality means that care and all services are provided according to accepted standards of clinical practice... NJAC 8:39-11.2(b)	F0658		02/02/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F0684	Residents 12, 120 were affected by this deficient practice. Upon notification resident 12 was no longer at the facility and physician was notified of change in condition for resident 120.	02/02/2026

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F0684 SS = D	Continued from page 43 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident receive treatment and care in accordance with professional standards of practice, by failing to ensure; a.) physicians' orders and approved plan of care were followed for 1 of 31 residents (Resident #120), b.) physician was notified of change in condition of 1 of 2 residents (Resident #120), and c.) recommendations were followed through and physician's orders were clarified for 1 of 2 residents, (Resident #12), reviewed for [redacted]. 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 well-being, 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." 1.On 1/21/26 at 10:44 AM, Surveyor #1 (S #1)	F0684	Continued from page 43 All residents on hospice services and those who are diabetic have the potential to be affected by this deficient practice. All hospice residents and those with diabetes where audited to ensure physician notification when blood sugar is out of parameter. Assistant director of nursing / designee educated nurses on ensuring if recommendation from hospice is not followed ensuring documentation as to rationale as well as documenting notification of changes to the physician. Director of Nursing / Designee will audit 5 patients weekly x 4 weeks then monthly x 2 months to ensure compliance in following recommendations or having physician documentation if not following recommendations and ensuring nurses document physician notification with change in condition. Results of the audits will be presented at the quarterly QAPI meeting.	02/02/2026

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F0684 SS = D	Continued from page 44 observed Resident #12 lying asleep in bed. A review of Resident #12's Admission Record (AR; admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; [redacted] A review of Resident #12's most recent comprehensive Minimum Data Set (MDS) reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident's [redacted]. A review of Resident #12's [redacted] facility visit notes included the following: [redacted] [redacted] give [redacted] if [redacted] is not effective. A review of Resident #12's [redacted] electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) included the following orders: [redacted] There was not a second order for [redacted] as recommended. There was no progress note (PN) to indicate that the physician did not agree with the recommendation. Further review of the eMAR and eTAR did not reflect an order for [redacted] that had the indication for [redacted] was not effective. There was no PN to indicate the physician did not agree with the recommendation. On 1/22/26 at 10:01 AM, S #1 interviewed the [redacted] who stated that Resident #12 received [redacted] and that a [redacted] would visit the resident and make recommendations	F0684		02/02/2026

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F0684 SS = D	Continued from page 45 for orders and that if the physician agreed with the recommendations, then the physician would write the order. On 1/23/26 at 12:23 PM, S #1 interviewed Licensed Practical Nurse #1 (LPN #1) who stated that if the physician did not agree with a [redacted] recommendation, then there should be PN that would have physician not in agreement with the recommendation. LPN #1 stated that there should be two different orders for NJ Ex Order 26, 4B1 and one for [redacted] LPN #1 further stated that there should be a separate order for [redacted] that was recommended for [redacted] She added that there would be a PN if the physician did not agree with the recommendation. On 1/27/26 at 11:26 AM, S #1 interviewed the [redacted] floor [redacted]) who stated that the physician usually agreed to the [redacted] recommendations and that if the physician did not agree then there should be a note. On 1/27/26 at 1:55 PM, S #1 notified the [redacted] the concern that Resident #12's [redacted] recommendations were not followed for NJ Ex Order 26, 4B1 and [redacted] was not effective. On 1/28/26 at 1:50 PM, in the presence of the [redacted] stated that Resident #12's physician did not put a separate order for [redacted] based on the medical record and the resident's [redacted] rate was stable. S #1 asked the [redacted] if an order for [redacted] was for two different reasons should the order be separated. The [redacted] stated that it would depend on the condition of the resident. 2. On 1/29/26 at 8:22 AM, Surveyor #2 (S #2) reviewed the closed medical records of Resident #120, and revealed: A review of the AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to NJ Ex Order 26, 4B1 [redacted]	F0684		02/02/2026

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F0684 SS = D	Continued from page 46 A review of the most recent MDS revealed that the NJ Ex Order 26, 4B1 A review of the most recent quarterly MDS with an ARD NJ Ex Order 26, 4B1 reflected on Section NJ Ex Order 26.4(b)(1) , a BIMS score of NJ Ex Order 26, 4B1, which reflected resident's NJ Ex Order 26, 4B1. Section NJ - Special Treatments, Procedures, and Programs reflected that the resident received NJ Ex Order 26 and was NJ Ex Order 26, 4B1. A review of the personalized Care Plan (CP), with a focus that Resident # 120 was on NJ Ex Order 26, 4B1 related to NJ Ex Order 26, 4B1 that was initiated on NJ Ex Order 26, 4 and revised on NJ Ex Order 26, 4B. A review of the NJ Ex Order 26, 4B1 orders, eMAR, and eTAR revealed a physician order (PO) for the following: -NJ Ex Order 26, 4B1 as ordered: 7 AM – 3 PM shift: NJ Ex Order 26, 4B1 3 PM – 11 PM shift: NJ Ex Order 26, 4B1 11 PM – 7 AM shift NJ Ex Order 26, 4B1 NJ Ex Order 2) in the afternoon 3 PM – 11 PM shift: Order date NJ Ex Order 26, 4 d/c (discontinue) date NJ Ex Order 26, 4B The above order was plotted every shift, there were no documented amount, and did not follow the PO. -NJ Ex Order 26, 4B1 inject as per sliding scale: if 0 - NJ Ex O = 0 units call U. S. FOIA (b) (2)) if <70 and follow NJ Ex Order 26, 4B1; 71 - 150 = 0 units; 151 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 400 = 10 units greater than 401 = give 10 units and U. S. FOIA (b) (2), NJ Ex Order 26, 4B1 -Order date NJ Ex Order 26, 4B -d/c date NJNJ Ex Order 26, The eMAR showed on NJ Ex Order 26, 4B at 4 PM, NJ Ex Order 26, 4B1 There was no documented evidence that the MD was called or notified according to the PO above. -If Resident is NJ Ex Order 26, 4B1 PRN for	F0684		02/02/2026

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F0684 SS = D	Continued from page 47 NJ Ex Order 26, 4B1 or NJ Ex Order 26, 4B1 -Order date NJ Ex Order 26, 4 -d/c date NJ Ex Order 26, 4B The eMAR did not reflect that the order above for PRN NJ Ex Order 26, 4B1 was administered for NJ Ex Order 26, 4B on NJ Ex Order 26, 4B. - If Resident is alert and able to swallow. PRN for NJ Ex Order 26, 4B1 NJ Ex Order 26, 4B1 within NJ Ex Ord Order date NJ Ex Order 26 -d/c NJ Ex Order 26, 4B1 The eMAR did not reflect that the order above for PRN to give meals or snacks within 1 hr was administered for NJ Ex Order 26, 4B1 Further review of the eMAR revealed that there was no documented evidence that the NJ Ex O was checked and followed the PO on NJ Ex Order 26, 4B1. A review of the PN with an effective date of NJ Ex Order 26, 4B at 2:06 PM, that was electronically signed by LPN #2, Note Text: "0730 (7:30 AM) Resident NJ Ex checked and was NJ Ex NJ Ex Order 26, 4B1 given NJ Ex Order 26, 4B1 0735 (7:35 AM) resident NJ Ex Order 26, 4B1 which is a unit of measurement used to express the NJ Ex Order 26.4(b)(1) Given another cup of orange juice and cup of milk. 0745 (7:45 AM) NJ Ex Order 26, 4B1 0805 (8:05 AM) NJ Ex Order 26.4(b)(1) 0840 (8:40 AM) Resident picked up by Medical Transport via stretchers for NJ Ex Order 26. Vital signs obtain prior and within normal limits. 11:30 (11:30 AM) Resident returned from NJ Ex Order 26, 4B1 canceled due to NJ Ex Order 26, 4B1 Vitals signs obtained and within normal limits."	F0684		02/02/2026

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F0684 SS = D	Continued from page 48 Further review of the medical records revealed that there was no documented evidence that the physician (also known as the MD) was notified of the [NJ Ex O] according to the PO and notified of the change in condition with regard to [NJ Ex O]. There was no documented evidence that the PN interventions that were documented for glucagon, milk, and orange juice were signed off as given in the eMAR. On 1/29/26 at 8:35 AM, S #2 interviewed the [U. S. FOIA] who informed S #2 that the facility's practice was to initiate an [NJ Ex Order 26, 4B1] if there was a change in condition of a resident that included [NJ Ex Order 26, 4B1] and the resident was transferred to the hospital. She further stated that if the resident was not transferred to the hospital, the nurse would initiate the SBAR (stands for Situation, Background, Assessment, and Recommendation, and it is a structured communication tool used in nursing to enhance clarity and efficiency in conveying critical patient information) and document also in the PN. The [U. S. FOIA] also stated that SBAR is done if there was a change in resident for example if the resident would be needing an [NJ Ex Order 26, 4B] or treatment. On that same date and time, the [U. S. FOIA] stated that if the resident had an order for [NJ Ex Order 26, 4B1] treatment in the eMAR, the nurse had to follow it and administer it according to the PO. The [U. S. FOIA] stated that the nurse had to document in the eInteract or PN, if they administered med, and to sign the eMAR. She further stated that the nurse had to call and notify the MD of the change in condition and document also in PN. At that time, S #2 notified the [U. S. FOIA] of the above concerns with [NJ Ex O] orders not being followed, PN, no documented evidence the physician was notified of changes to the resident, no further monitoring of [NJ Ex] in the eMAR, nurse did not sign and did not document that the PRN orders for [NJ Ex Order 26, 4B1] were administered. The [U. S. FOIA] stated that the physician should have been notified, documented the [NJ Ex] in the eMAR, signed the PRN orders for [NJ Ex Order 26, 4B1] and the nurse should have done eInteract, and followed up the [NJ Ex O]. S #2 asked for copy of policies with regard to notification of changes and following PO. On 1/29/26 at 9:22 AM, S #2 interviewed LPN #2,	F0684		02/02/2026

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F0684 SS = D	Continued from page 49 who informed S #2 that as per facility's process or standard of practice, when a resident had change in condition, example was [redacted] "we give" orange juice and milk according to the PO. LPN #2 stated that if it was [redacted] or below "we give" [redacted]), sign the eMAR, monitor, call the doctor, and obtain further orders. She further stated that afterward "we" document in the electronic medical record, PN, "we" also do SBAR. At that time, S #2 notified LPN #2 of the above findings and concerns. LPN #2 informed S #2 that she remembered that day, the resident [redacted] and it was the [redacted] that the resident the [redacted]. She added that it was morning when "I" came in and "I" was doing rounds when the [redacted]) notified her about the resident would not want to eat and looked like [redacted] but awake. LPN #2 stated that she could not remember the [redacted] at that time. LPN #2 further stated that she gave [redacted] notified the Nursing Supervisor, "I" rechecked 5-10 minutes it was still low the [redacted] then the [redacted] came, the [redacted] then was 36, and "I" administered the [redacted] I called the doctor, and I remembered the doctor screamed on me because he was rounding in the hospital when I called and ordered to give another [redacted]. Afterward, LPN #2 stated that she was unsure if she documented that she called the doctor at that time. On 1/28/26 at 1:47 PM, the survey team met with the [redacted], and S #2 notified them of the above findings and concerns with Resident #120. On 1/29/26 at 11:43 AM, the survey team met with the [redacted]. The [redacted] stated there was no policy with regard to SBAR and eInteract, it was "just a tool that we follow and do". The [redacted] stated that there was no additional information to provide. A review of the facility's "Notification of Changes Policy" that was provided by the DON, with a reviewed/revised date of 9/1/25, revealed under policy: the purpose is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification…Compliance Guidelines: the facility must inform the resident,	F0684		02/02/2026

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F0684 SS = D	Continued from page 50 consult with the resident's physician when there is a change requiring such notification… Further review of the above "Notification of Changes Policy" did not include information documentation of notification. On 1/29/26 at 1:50 PM, the survey team met with the [redacted] for exit conference, and there was no additional information provided by the [redacted] NJAC 8:39-3.2(a,b); 11.2(b); 27.1(a)	F0684		02/02/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of the medical record, and review of other facility documentation, the facility failed to maintain infection control practices to reduce the risk of infection during [redacted] observed (Resident's #7). This deficient practice was evidenced by the following: On 1/21/26 at 11:12 AM, the surveyor observed Resident #7 sleeping in bed.	F0686	Resident 7 was affected by this deficient practice. Upon notification education was provided to [redacted] regarding use of her marker and handwashing after removing gown and gloves. All residents with wounds have the potential to be affected by this deficient practice. [redacted] on hand washing after removing gown and gloves and using a marker during wound care. Director of nursing / designee will audit one wound care treatment weekly x 4 weeks then monthly x 2 months to ensure compliance with handwashing and utilization of marker. Results of audits will be presented at the quarterly QAPI meeting.	02/02/2026

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F0686 SS = D	Continued from page 51 A review of Resident #7's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: [redacted] A review of Resident #7's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's [redacted] skills for daily decision making were [redacted]. On 1/28/26 at 10:18 AM, the [redacted] started Resident #7's [redacted]. The [redacted] while placing some of the supplies on the table doffed (take off) her gloves and performed hand hygiene (hh) and donned (put on) a new pair of gloves. The [redacted] opened the [redacted], put her hand in her pants pocket and removed a marker from her pocket. The [redacted] did not disinfect the marker. The [redacted] then dated the dressing and placed the marker back in her pocket. The [redacted] then doffed her gloves and donned a new pair of gloves. The [redacted] did not perform hh after doffing her gloves and before donning the new pair. The [redacted] then started the treatment for the [redacted]. After the [redacted] wiped dry the right heel the [redacted] performed handwashing (hw) for 9 seconds outside the flow of water. The [redacted] donned a pair of new gloves, wiped the resident's right ankle with [redacted]. The [redacted] doffed her gloves then donned a new pair of gloves. The [redacted] did not perform hh. Later in the treatment for the [redacted], the [redacted] performed hw for 20 seconds outside the flow water, rinsed her hands and then turned off the faucet with her wet hand before taking a paper towel to dry her hands. The [redacted] did not use a new dry paper towel to turn off the faucet. At the end of the treatment, after performing appropriate hw and donning gloves, the [redacted] removed all the supplies from the table and threw them in a plastic bag. The [redacted] then removed her gown and gloves and left the room. The [redacted] did not perform hh and then proceeded to touch the handle of the treatment cart. The [redacted] then put her hand in her pocket to remove the keys to the treatment cart and opened the cart. The [redacted] then donned a new pair of gloves and took out disinfectant wipes from the treatment cart. In addition, during the wound treatments of both heels, the [redacted] was holding the resident's [redacted]. The [redacted] did not put	F0686		02/02/2026

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F0686 SS = D	Continued from page 52 down a clean surface under the resident's [NJ Ex Order] during the treatments. The surveyor observed that the resident's [NJ Ex Order] were close to touching the bed sheet and the blanket on more than one occasion. The surveyor then interviewed the [U. S. FO] [U. S. FO] regarding the wound treatment observation. The [U. S. FO] stated that she took the marker out her pocket and that she made a mistake and should have performed hh after removing gown and gloves. On 1/28/26 at 11:57 AM, the surveyor interviewed the [U. S. FOIA (b) (2)] regarding wound treatment. The [U. S. FO] stated that she had to get back to the surveyor regarding the marker. The [U. S. FO] stated that it was good practice to place something under the area but that it was not mandatory. The [U. S. FO] stated that hh should be performed before putting on gloves and after removing gloves. The [U. S. FO] further stated that the faucet should be running while drying hands and that the faucet would be shut after hands were dried and with a new paper towel. The [U. S. FO] also stated that the [U. S. FOIA] was good and that she just got nervous. The [U. S. FO] stated that the nurses were constantly in-serviced. On 1/28/26 at 12:46 PM, the [U. S. FO] stated that if the nurse pulled the marker from her pocket, wrote on the dressing, put it back in her pocket and then changed gloves, that it was okay. On 1/28/26 at 2:22 PM, the surveyor notified the [U. S. FOIA (b) (2)] the concerns regarding Resident #7's [NJ Ex Order 2] treatment observation which included not disinfecting the marker, hw for 9 seconds, not performing hh several times after removing gloves, turning off the faucet with wet hand, and not placing a clean surface under the resident's [NJ Ex Ord] On 1/29/26 at 11:43 AM, in the presence of the [U. S. FOIA (b) (2)] stated that in regards to the hand hygiene during treatment observation the nurse was brand new and that she was not going to dispute the handwashing. The [U. S. FOIA D] did not provide any additional information.	F0686		02/02/2026

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F0686 SS = D	Continued from page 53 A review of the facility's "Wound Treatment Management Policy" with a reviewed/revised date of 9/1/25, included the following: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician order. The policy did not contain any information regarding process for the wound treatment. A review of the facility's "Hand Hygiene Policy" with a reviewed/revised date of 9/1/25, included the following: All staff will perform proper hand hygiene to prevent the spread of infection to other personnel, residents, and visitors… 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice… 5. Hand hygiene technique when using soap and water:.. c. Rub hands together vigorously for at least 20 seconds… e .Dry thoroughly with a single-use towel. f. Use clean towel to turn off the faucet. 6. Additional considerations: a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. N.J.A.C. 8:39-19.4(a)k	F0686		02/02/2026
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F0693	Resident 51 was [NJ Ex Order 26.4(b)(1)] this deficient practice, upon notification physician was notified of [NJ Ex Order 2] and medication order was changed to be administered via [NJ Ex Orde] All residents who are NPO (nothing by mouth) have the potential to be affected by this deficient practice. All residents who are NPO were audited to ensure all medications are scheduled to be administered via feeding tube.	02/02/2026

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F0693 SS = D	Continued from page 54 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) clarify physician's orders (PO) to ensure appropriate care and services for a resident receiving [redacted] and b.) to notify the physician of a [redacted]) as per physician order. This deficient practice was identified for 1 of 2 residents (Resident #51), reviewed for [redacted] This deficient practice was evidenced by the following: On 1/21/26 at 11:17 AM, the surveyor observed the resident sitting in a wheelchair, not able to answer questions. The surveyor interviewed the [redacted] floor U. S. FOIA (b) (2) who stated Resident #51 was on NJ Ex Order 26.4(b)(1) NJ Ex Order 26, 4B1 NJ Ex Order 26.4(b)(1) [redacted]). A review of the Admission Record (an admission summary) which revealed diagnoses that included but not limited to: NJ Ex Order 26, 4B1 [redacted] A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted] revealed a Brief Interview of Mental Status (BIMS) score of [redacted] indicating NJ Ex Order 26, 4B1 , and that the resident was on [redacted]	F0693	Continued from page 54 Assistant Director of Nursing / designee educated nurses on ensuring medications are ordered to be given through the appropriate route. Director of Nursing / designee will conduct an audit of all NPO residents to ensure medications are scheduled to be given via feeding tube, weekly x 4 weeks then monthly x 2 months. Results of the audits will be presented at the quarterly QAPI meetings.	02/02/2026

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F0693 SS = D	Continued from page 55 A review of the resident's Care Plan (CP) included that Resident #51 was at NJ Ex Order 26, 4B1 due to: NJ Ex Order 26, 4B1), date initiated on NJ Ex Order 26. The resident required TF related to (r/t) NJ Ex Order 26, 4B1 date initiated on NJ Ex Order 26, 4B. A review of the Order Summary revealed the following PO: -Ordered on NJ Ex Order 2, N NJ Ex Order 26.4(b)(1) -Ordered on NJ Ex Order 26, NJ Ex Order 26, 4B1 directly into the NJ Ex Order 26, 4B through the NJ Ex Order 26, 4B1. This NJ Ex Order 2 often called a NJ Ex O provides NJ Ex Order 26.4(b)(1) and medication to patients who NJ Ex Order 26, 4B1 or NJ Ex Order 26.4(b)(1) due to NJ Ex Order 26, 4B1 Total provides NJ Ex Order 26, 4B1 -Ordered on NJ Ex Order 26, 4B1 as needed (PRN) for NJ Ex Order 26, 4B1 the NJ Ex Order 26.4 of NJ Ex Order 26, 4B1 -Ordered on NJ Ex Order 26, 4B1 PRN for NJ Ex Order 26, 4B1 total does not to exceed NJ Ex Order 26 not to exceed NJ Ex Order 26.4(b)(1) -Ordered on NJ Ex Order 26, 4B1 NJ Ex Order 26. Notify the physician for a NJ Ex Order 2 NJ Ex Order 26, 4B1 or more within 24 hours and/or or more within one week, everyday shift. A review of the resident's weight revealed on NJ Ex Order 26 a weight of NJ Ex Order 26, 4B. and on NJ INJ Ex Order 26 NJ Ex Order 26, 4B1). On 1/23/26 at 10:50 AM, the surveyor reviewed with the NJ Ex O floor U. S. FOIA (b) regarding the concerns on the electronic Medication Administration Record (eMAR), the orders for NJ Ex Order 26, 4B1 and the order to notify physician for NJ Ex Order 26, 4B1. The U. S. FOIA (b) confirmed the order for NJ Ex Order 26, 4B1 were entered incorrectly. The U. S. FOIA (b) further stated that they (nurse) should have called the doctor for	F0693		02/02/2026

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F0693 SS = D	Continued from page 56 the 2-5 lbs. weight gain on 1/22/26 as ordered. On 1/23/26 at 11:16 AM, the surveyor and the [U. S. FOIA (b) (2)] reviewed all the nursing progress notes (PN) and the [U. S. FOIA (b) (2)] confirmed that for [NJ Ex Order 26, 4B1] [NJ Ex Order 26, 4B1] the doctor was not notified of the [NJ Ex Order 26, 4B1] and PO was not followed. She further stated that it was the responsibility of the nurses to notify the doctor and follow the PO. On 1/28/26 at 2:36 PM, the survey team met with the U. S. FOIA (b) (2) and the surveyor notified them of the above findings and concerns. The [U. S. FOIA] stated that medications were corrected after surveyor's inquiry. On 1/29/26 at 9:15 AM, the surveyor notified the [U. S. FOIA] regarding the concern with the physician order not being followed for notifying physician for [NJ Ex Order 2] On 1/29/26 at 11:45 AM, the survey team met with the U. S. FOIA (b) (2), and there was no further information provided by the [U. S. FOIA (b)] A review of the facility's "Provision of Physician Ordered Services Policy" dated 9/1/25, revealed under Definition, Professional Standards of Quality means that care and all services are provided according to accepted standards of clinical practice... A review of the facility's "Medication Administration Policy" dated 9/1/25, revealed under Policy Explanation and Compliance Guidelines #12c..... administer in accordance with facility policy for the relevant route of administration... NJAC 8:39-27.1(a)	F0693		02/02/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with	F0698	Resident 94 was affected by this deficient practice. Upon notification order was changed to accommodate [NJ Ex Order 26] times and education was done to ensure [NJ Ex Order 26, 4B1] is being followed. All residents who receive dialysis and/or have a fluid restriction have the potential to be affected by	02/02/2026

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F0698 SS = D	Continued from page 57 professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide care and services in accordance with professional standards with regard to a.) medication administration to accommodate [NJ Ex Order 26] schedule times and b.) following the physician's order for [NJ Ex Order 26.4(b)(1)] for 1 of 2 residents, (Resident #94), reviewed for [... Ex Order 26] services, and 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 and 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 regimens 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 1/21/26 at10:59 AM, the surveyor observed Resident #94 was not in their room. The [NJ Ex O] floor [U. S. FOIA (b) (2)] stated the resident was in the [NJ Ex Order 26.4(b)(1)]. The [U. S. FOIA (b)] also stated the resident's [NJ Ex Order 26, 4B1] were on [NJ Ex Order 26, 4B1]. On 1/22/26 at 11:28 AM, the resident was out for [NJ Ex Order 26] and the [U. S. FOIA (b)] stated that the resident left at 9:00 AM and would come back to the facility at around 2:30 PM-3:00 PM.	F0698	Continued from page 57 this deficient practice. All dialysis residents reviewed to ensure medications are ordered to accommodate dialysis times and that fluid restrictions are being followed. Assistant director of nursing / designee educated nurses on ensuring medications are plotted when the resident is not at dialysis and that residents are compliant with fluid restriction. Director of nursing / designee will audit all dialysis residents weekly x 4 weeks, then monthly x 2 months to ensure medications are due to be given when the resident is not at dialysis and that fluid restrictions are being followed. The results of the audits will be reviewed on the quarterly QAPI meeting.	02/02/2026

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F0698 SS = D	Continued from page 58 A review of the Admission Record (an admission summary) revealed diagnoses which included but not limited to NJ Ex Order 26, 4B1 A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of NJ Ex Order 26, 4B, revealed a Brief Interview of Mental Status (BIMS) score of NJ Ex Order 26, 4B1 indicating NJ Ex Order 26, 4B1, and that resident was on NJ Ex Order 26, A review of the resident's Care Plan (CP) indicated the resident with NJ Ex Order 26, 4B1 related to NJ Ex Order 26 A review of the Order Summary Report revealed the following Physician Order (PO): -Ordered on NJ Ex Order 26, 4B, for NJ Ex Order 26, on NJ Ex Order 26, 4B1; pick up time at NJ Ex Order 26, 4B1 and NJ Ex Order 26, 4B1 at NJ Ex Order 26, 4B1 -Ordered on NJ Ex Order 26, 4B, for NJ Ex Order 26, 4B1 Give NJ Ex Order 26, 4B1 in the morning for NJ Ex Order 26 hold for NJ Ex Order 26, 4B1 less than NJ Ex Ord -Ordered on NJ Ex Order 26, for NJ Ex Order 26, 4B1 as ordered: NJ Ex Order 26, 4B1). Noted NJ Ex Order from NJ Ex Orde NJ Ex Order 26, 4B1 was not included. 7 AM - 3 PM shift: NJ Ex Order 26, 4B1 3 PM - 11 PM shift: NJ Ex Order 26, 4B1 11 PM - 7 AM shift: NJ Ex Order 26, 4B1 Total NJ Ex Order 26, every shift. Further review of the electronic Medication Administration Record (eMAR) revealed the PO for NJ Ex Order 26, 4B1 was not followed on the following dates: On 1/13/26, a NJ Ex Order 26, 4B1 was administered.	F0698		02/02/2026

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F0698 SS = D	Continued from page 59 On [redacted] a NJ Ex Order 26, 4B1 was administered. On [redacted], a NJ Ex Order 26, 4B1 was administered. On [redacted], a NJ Ex Order 26, 4B1 was administered. On [redacted], a NJ Ex Order 26, 4B1 was administered. On [redacted], a NJ Ex Order 26, 4B1 administered. -Ordered on [redacted], for NJ Ex Order 26, 4B1 [redacted] NJ Ex Order 26, 4B1 [redacted] times a NJ Ex Order 26, 4B1 was timed for 9:00 AM, 1:00 PM, and 5:00 PM. Further review of the eMAR revealed on [redacted] revealed a legend #7 ([redacted]) was documented and medication (med) was not administered. -Ordered on [redacted], for NJ Ex Order 26, 4B1 [redacted] NJ Ex Order 26, 4B1 [redacted]. Further review of the eMAR revealed on [redacted] revealed a legend #7 (NJ Ex Order 26, 4B1) was documented and med was not administered. On 1/23/26 at 9:57 AM, the surveyor observed Resident #94 lying in bed, with [redacted] on the bedside table, and stated they [redacted]. On 1/23/26 at 10:12 AM, the surveyor reviewed with the U. S. FOIA (b) (6), in the presence of the primary U. S. FOIA (b) (6) [redacted]), regarding the NJ Ex Order 26, 4B1 [redacted] and NJ Ex Order 26, 4B1 medications (meds) were not administered due to resident out on [redacted] and the NJ Ex Order 26, 4B1 not followed. The U. S. FOI [redacted] stated that the resident came back yesterday at 2:45 PM from [redacted]. The U. S. FOIA (b) [redacted] and the U. S. FO [redacted] also reviewed all the nursing progress notes (PN) and confirmed the meds should have been adjusted according to [redacted] time. Both also acknowledged the order for NJ Ex Order 26, 4B1 was not followed. The U. S. FOIA (b) [redacted] stated, "We have to correct that one now". On 1/28/26 at 2:32 PM, the survey team met with	F0698		02/02/2026

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F0698 SS = D	Continued from page 60 the U. S. FOIA (b) (2) and the surveyor notified of the above findings and concerns concerning the meds and NJ Ex Order 26, 4B1 orders. The U. S. FOIA stated that regarding the NJ Ex Order 26.4(b)(1) the resident was noncompliant. The surveyor asked what was the expectation from nurses when a resident was noncompliant with NJ Ex Order 26.4(b)(1), and the U. S. FOIA replied, "I expect them to call the doctor and clarify and document". The surveyor asked the U. S. FOIA if the nurses documented each time, and there was no response from the U. S. FOIA. Later, the U. S. FOIA stated that noncompliance of the resident was included in the CP after surveyor's inquiry. On 1/29/26 at 11:45 AM, the survey team met with the U. S. FOIA (b) (2), and there was no further information provided by the U. S. FOIA (b) A review of the facility's "Hemodialysis Policy" dated 9/1/25, revealed under Compliance Guidelines #9, The facility will communicate with the .... attending physician.... any.....med.... withholding of certain meds....#13g, The facility will ensure that the PO for dialysis include: Any fluid restriction if ordered by the physician... A review of the facility's "Fluid Restriction Policy" dated 9/1/25, revealed under Policy, It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to PO... NJAC 8:39-11.2(b),27.1(a),29.2(d)	F0698		02/02/2026
F0725 SS = D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance	F0725	Resident 13 was affected by this deficient practice. Upon notification resident was provided with NJ Ex Order 26, 4B1. All residents who are incontinent have the potential to be affected by this deficient practice. All residents checked to ensure they were clean and dry, any concerns where addressed in real time. Assistant director of nursing / designee educated all nursing staff to ensure residents are provided with incontinent care timely and are not double briefed.	02/02/2026

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F0725 SS = D	Continued from page 61 with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (f) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (f) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Complaint NJ#s: 384182, 384183, 384186, 384188, 2573473, and 2615149 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure residents received timely and appropriate[NJ Ex Order 26, 4B1] to achieve their highest practical wellbeing. This deficient practice was identified for 1 of 4 residents (Resident#13) observed during[NJ Ex Order 26, 4B1] and was evidenced by the following: On 1/21/26 at 9:07 AM, the survey team entered the facility and observed the Nursing Home Resident Care Staffing Report (NHRCSR) for[NJ Ex Order 26], 7 AM-3 PM shift with a census of 118 and the ratio of the[U. S. FOIA (b) (2)] to Resident was 1:14.8. A review of the provided nursing staffing schedule for[NJ Ex Order 26], revealed that there were total of 28 residents in the[NJ Ex O] floor nursing unit and two[U. S. FOIA (b)] On[NJ Ex Order 26] at 11:40 AM, the surveyor went to[NJ Ex O] floor and interviewed the[U. S. FOIA], and the surveyor asked the[U. S. FOIA] how many residents she had in her assignment. The[U. S. FOIA] responded, "a lot, I cannot even tell you how many". She stated about 14	F0725	Continued from page 61 Director of nursing / designee will do incontinence checks on 10 residents weekly x 4 weeks and then monthly x 2 months. Results of the audits will be presented at the quarterly QAPI meetings.	02/02/2026

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F0725 SS = D	Continued from page 62 residents, and she stated it was hard, but she was doing everything to finish. She further stated "right now" she was not done with am (morning) care. She confirmed that there were only two [redacted] in the [redacted] floor unit. The [redacted] informed the surveyor that they [redacted]) utilized the electronic medical records for signing off care provided to the resident that included incontinent care. On 1/22/26 at 8:52 AM, the surveyor went to [redacted] floor nursing unit and observed an NHRCSR posted dated [redacted] 7 AM-3 PM shift, current census was 117, there were total of 10 [redacted], and the ratio 1 CNA:11.7 Residents. On 1/23/26 at 8:50 AM, the surveyor asked the [redacted] floor U. S. FOIA (b) (2) to accompany the surveyor for NJ Ex Order 26, 4B1. The [redacted] confirmed that Resident #13 was [redacted] with NJ Ex Order 26, 4B1. Both the surveyor and the [redacted] went inside the resident's room, and the resident allowed the [redacted] to check their NJ Ex Order 26, 4B1. The surveyor observed the [redacted] performed hand hygiene, donned (put on) gloves, and checked the resident's [redacted] Both the surveyor and the [redacted] observed Resident #13 with NJ Ex Order 26, 4B1 and [redacted]. The surveyor did not observe [redacted] On that same date and time, the surveyor observed the [redacted] checked Resident #13's pads and the [redacted] confirmed it was NJ Ex Order 26, 4B1 that included folded linen and cloth type chuck and there was a [redacted]. The [redacted] informed the resident that she would [redacted] the resident herself. At that same time, the surveyor observed the [redacted] went to the resident's toilet room and performed handwashing. The [redacted] stated that she was unaware that the resident requested [redacted] NJ Ex Order 26, 4B1, and if the resident did ask, that should have been in the resident's care plan (CP). The [redacted] further stated that she was unsure if it was in the CP. She also added that the facility did not allow NJ Ex Order 26, 4B1 unless it was asked by the resident due to NJ Ex Order 26, 4B1, and that the nurse should be aware to be added in the CP. The surveyor was unable to interview the [redacted]	F0725		02/02/2026

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F0725 SS = D	Continued from page 63 assigned to the resident at that time. On 1/23/26 at 10:29 AM, the surveyor reviewed the medical records of Resident #13, and revealed: A review of the Admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to: NJ Ex Order 26, 4B1 [redacted] A review of the personalized CP reflected a focus that the resident had potentia NJ Ex Order 26, 4B1 [redacted] hat was revised or [redacted], with an interventions that included but was not limited to assist with NJ Ex Order 26.4(b)(1). Further review of the CP for Resident #13 revealed there was no CP that the resident preferred to have NJ Ex Order 26, 4B1. There was no documented evidence that the resident had requested for NJ Ex Order 26, 4B1. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of [redacted], the brief interview for mental status (BIMS) score was NJ Ex Order 26, 4B1 which reflected that the resident NJ Ex Order 26, 4B1 Section [redacted] Functional Abilities: NJ Ex Order 26, 4B1 NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) was [redacted]. Section [redacted] NJ Ex Order 26, 4B1 was coded [redacted] (always [redacted] for NJ Ex Order 26, 4B1. Section [redacted] NJ Ex Order 26, 4B1 =no NJ Ex Order 26, 4B1. On 1/23/26 at 12:16 PM, the surveyor reviewed the NJ Ex Order 26.4(b)(1) task of the [redacted] in the electronic medical records and revealed, from [redacted] the question, "the ability to maintain NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) were checked off every shift. In addition, the [redacted] hygiene task revealed on [redacted], there was only one shift that signed off the task at 00:17 (12:17 AM),reflected that the resident was NJ Ex Order 26.4(b)(1) and	F0725		02/02/2026

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F0725 SS = D	Continued from page 64 required the assistance of NJ Ex Order 26.4(b)(1) for the resident to complete the activity. Further review of the toileting hygiene task revealed on NJ Ex Order 26.4(there was no documented evidence that the 7 AM-3 PM shift had signed off the task to reflect that care was provided, and no documented evidence that after 12:17 AM of NJ Ex Order 26, that NJ Ex Order 26, 4B1 was provided. On NJ Ex Order 26.4(b)(12:20 PM A review of the provided List of NJ Ex Order 26.4(b)(1 Residents by the U.S. FOIA (b)(6) revealed that Resident #13 was included. A review of the provided nursing staffing schedule for NJ Ex Order 26.4 revealed a census of 112 and there were two CNAs on the NJ Ex O floor in 7 AM – 3 PM shift. On NJ Ex Order 26.4 at 1:47 PM, the survey team met with the U. S. FOIA (b) (2)), and the surveyor notified them of the above findings and concerns with Resident #13. On 1/29/26 at 10:29 AM, the surveyor met with the U. S. FOIA (b) (2) for QAPI (Quality Assurance Performance Improvement) meeting and discussed the Facility Assessment that was provided to the surveyor with regard to staffing requirements. The U. S. FOIA (b confirmed that staffing concern had been part of facility's QAPI, and he was aware that the facility at times were unable to meet the New Jersey (NJ) required minimum staffing requirements or ratio for 1 CNA:8 Residents for 7 AM-3 PM, 1 CNA:10 Resident for 3 PM-11 PM, and 1 CNA:14 Residents for 11 PM-7 AM. On 1/29/26 at 11:43 AM, the survey team met with the U. S. FOIA (b) (2) for responses. The U. S. FOIA informed the surveyors that after inquiry with the staff, it was found out that it was the first time the resident had asked for NJ Ex Order 26.4(b)(1), and CP was updated to include the resident's request after surveyor's inquiry and observation. The U. S. FOIA further stated that aid was provided a one on one in service. A review of the facility's "Activities of Daily Living Policy" that was provided by the U.S. FOIA (with a	F0725		02/02/2026

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F0725 SS = D	Continued from page 65 reviewed/revised date of 10/1/25, reflected under policy statement, residents will provide with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation….2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene…c. Elimination (toileting)… A review of the facility's "Incontinence Policy" that was provided by the LNHA, with a reviewed/revised date of 9/1/25, reflected, based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Policy Explanation and Compliance Guidelines:...4. Residents that are incontinent with bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. On 1/29/26 at 1:50 PM, the survey team met with the U. S. FOIA (b) (2) for exit conference, and there was no additional information provided by the U.S. FOIA (b) NJAC 8:39-25.2(b); 27.2(h)	F0725		02/02/2026
F0732 SS = D	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F0732	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 nurse staffing information was immediately corrected to ensure it accurately reflected the daily census and staffing ratios. The HR Director and AIT completed a review of the previous 30 days of staffing postings and verified	02/02/2026

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F0732 SS = D	Continued from page 66 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure the accurate daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for 3 of 6 days during the annual re-certification survey. This deficient practice was evidenced by the following: On 1/21/26 at 9:07 AM, the survey team entered the facility. The surveyor observed the Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the U.S. FOIA (b)(6) The NHRCSR posted was dated 1/21/26, for the 7 AM-3 PM day shift with a current resident census of 118. The	F0732	Continued from page 66 that no additional deficient practices were identified Measures or systemic changes to ensure that the deficiency will not recur: Administrator provided reeducation to the U.S. FO and the U.S. FOIA (b)(6) emphasizing the requirement to post accurate census information for each shift on a daily basis. Inservice Education included proper reconciliation of daily census numbers, verification of staffing ratios before posting, and remediation procedure if discrepancies are identified 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. Recommendations will be reviewed submitted quarterly to The Quality Assurance Performance Improvement (QAPI)Committee, chaired by the Administrator.	02/02/2026

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F0732 SS = D	Continued from page 67 U. S. FOIA (b) (2)) informed the survey team on entrance that the resident census was 117 with no bed hold. There was a discrepancy on the provided census on admission and what was posted in the NHRCSR on 1/21/26. On 1/22/26 at 9:00 AM, the surveyor observed the NHRCSR posted by the front desk for 1/22/26, 7 AM-3 PM shift with a resident census of 117. The U. S. FOIA (b) provided the staffing sheet at 11:18 AM, which reflected a census for 118. The posted NHRCSR census of 117 did not match the provided staffing sheet census of 118 on 1/22/26. On 1/23/26 at 8:37 AM, the surveyor interviewed the Receptionist by the front desk, who stated, "The U. S. FOIA (b) (2)) is responsible for posting this (NHRCSR), posted around 8 AM". On 1/23/26 at 9:28 AM, the surveyor interviewed the U. S. F who stated that on a daily basis "I run the schedule", do the count, come early in the morning, input in the state report, then print it out and post it in the lobby around 7-7:30 AM. The U. S. F further stated that sometimes she would call the U. S. FOIA (b) (2) to post it if "I am out or running late". The [redacted] also stated that she was responsible for posting and that "I am aware of the regulation that the numbers should be accurate, staff versus residents". On 1/27/26 at 10: 50 AM, the surveyor observed the NHRCSR posted with a resident census of 116. The U. S. FOIA (b) provided the staffing sheet with census of 118. On 1/28/26 at 2:40 PM, the survey team met with the U. S. FOIA (b) (2)), and the surveyor notified them of the above findings and concerns with the NHRCSR and staffing sheet discrepancies. On 1/29/26 at 11:14 AM, the surveyor notified the U. S. F regarding the three days posted NHRCSR did not match the census in the staffing sheets. The U. S. FO stated, "I do send out the staffing with the census of	F0732		02/02/2026

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F0732 SS = D	Continued from page 68 that date, the night before. I do change it the morning that I come in. The posting for those days should have been accurate". On 1/29/26 at 11:45 AM, the survey team met with the U. S. FOIA (b) (2). The U. S. FOIA (b) stated that the staffing reporting was done the night before and that there were two discharges that did not come in after midnight. The U. S. FOIA (b) stated that he was aware of the regulation that the posted staffing should be accurate and posted the beginning of each shift. He further stated that the posted NHRCSR was not changed before 7AM. The U. S. FOIA (b) stated that they had the whole day to update or revised the NHRCSR the following day. A review of the facility's "Staffing Policy" dated 9/1/25, revealed under Policy Statement, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans... The facility policy did not include information about the regulations for posting and the management staff stated there were no other policies for staffing. NJAC 8:39-41.2(a,b,c,d)	F0732		02/02/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.	F0756	Resident 12 and resident 48 were affected by this deficient practice. Upon notification consultant pharmacy report was uploaded for resident 12 and physician was notified of U. S. FOIA (b) (2) recommendations for resident 48 and orders updated. All residents with pharmacy consultant recommendations have the potential to be affected by this deficient practice. Pharmacy consultant reports from prior visit reviewed by Assistant Director of Nursing to ensure all were addressed and uploaded into the electronic medical record. Director of Nursing educated Unit Managers regarding pharmacy consultant reports were completed and Unit Clerks educated regarding uploading of reports to the electronic medical record. Director of Nursing / designee will audit 10 residents	02/02/2026

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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
F0756 SS = D	Continued from page 69 (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to a.) ensure that a resident received a monthly medication review from a pharmacy consultant for 1 of 5 residents reviewed for unnecessary medication (Resident #12) and b.) act on the NJ Ex Order 26.4(b)(1) Medication Regimen Review (MRR) in a timely manner for 1 of 5 residents, (Resident #48), observed on the medication pass observation (med pass). This deficient practice was evidenced by the following: 1.On 1/21/26 at 10:44 AM, Surveyor #1 (S #1) observed Resident #12 lying asleep in bed. A review of Resident #12's Admission Record (AR; admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to: NJ Ex Order 26, 4B1 [redacted]. A review of Resident #12's most recent comprehensive Minimum Data Set (MDS) reflected	F0756	Continued from page 69 charts weekly x 4 weeks then monthly x 2 months to ensure pharmacy consultant reports are addressed and uploaded to the electronic medical record. Results of the audit will be addressed at the monthly Quality Assurance Performance Improvement meeting. Date of Completion: 01/29/2026	02/02/2026

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 01/29/2026

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F0756 SS = D	Continued from page 70 that the resident had a Brief Interview for Mental Status (BIMS) score of [NJ Ex Order 26, 4B1] which indicated the resident's [NJ Ex Order 26, 4B1] A review of Resident #12's Progress Notes (PN) indicated that the last pharmacy consultant visit was on [redacted]. A review of Resident #12's electronic medical record (EMR) did not reflect any CP document that was uploaded. On 1/27/26 at 1:12 PM, S #1 interviewed the 6th floor [U. S. FOIA (b) (2)] who stated that the CP visited one time a month and that the report went to the [U. S. FOIA (b) (2)] On 1/27/26 at 1:15 PM, S #1 interviewed the [redacted] who stated that the CP visited monthly. S #1 asked if the expectation was for the CP to review all the residents. The [redacted] stated that the CP was expected to review everyone and that they had access to the EMR. The [redacted] added that the CP reviewed residents when they returned from a hospital stay. On 1/27/26 at 1:55 PM, S #1 notified the [redacted] the concern that Resident #12's last MMR done by the CP documented in the resident's medical record was on [redacted]. On 1/28/26 at 2:03 PM, in the presence of the [U. S. FOIA (b) (2)] provided S #1 with a document that was dated 1/6/26 from the CP which had listed no recommendations and included the following: Permanent Record-Do Not Remove-Do Not Thin. S #1 asked the [redacted] if the document should have been part of the resident's medical record. The [redacted] stated that the CP was at the facility on [redacted] and [redacted] and that the resident was in the [redacted] then. The [redacted] stated that the resident returned to the facility on [redacted] S #1 notified the [redacted] that the document was not uploaded into the EMR. The [redacted] stated that the document was not uploaded since the CP would document a note in the PN. S #1 notified the [redacted] that there was not a PN in the resident's medical record for the [redacted] visit.	F0756		02/02/2026

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F0756 SS = D	Continued from page 71 The [U. S. FOIA (b)] did not provide any additional information. A review of the facility's "Medication Monitoring/Side Effects Policy" with a reviewed/revised date of 9/1/25, included the following:..6. Each resident's medication regimen is reviewed by a licensed pharmacist at designated intervals and whenever changes in condition that could be related to medications are noted…. 2. On 1/23/26 at 8:44 AM, Surveyor #2 (S #2) observed Licensed Practical Nurse #1 (LPN #1) assigned to Resident #48 prepare and administer due medications (meds) for the resident. S #2 observed the LPN #1 prepare [NJ Ex Order 26, 4B1] [redacted] S #2 observed these orders on the resident's electronic medication administration record (eMAR) displayed on LPN #1's computer screen. S #2 asked LPN #1 why they were giving the same medication (med) in cap and liquid form to the resident. LPN #1 stated that the resident was very constipated and they needed it. LPN #1 documented the administration of meds and S #2 concluded the observation. S #2 reviewed the EM for Resident #48. A review of the AR reflected that the resident was admitted to the facility with diagnoses of, but not limited t [NJ Ex Order 26, 4B1] [redacted] A review of the quarterly MDS, with an ARD of [NJ Ex Order 26, 4B] under Section [NJ E] revealed a BIMS score of [NJ Ex Order 26, 4B1], indicating that the resident had [NJ Ex Order 26] Section [NJ E] [NJ Ex Order 26, 4B1] revealed that the resident was frequently [NJ Ex Order 26, 4B1] [NJ Ex Order 26, 4]. A review of Order Summary Report reflected the following orders: [NJ Ex Order 26, 4B1] Give [NJ Ex Order 26, 4B1], with an order date of [NJ Ex Order 26, 4]	F0756		02/02/2026

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F0756 SS = D	Continued from page 72 NJ Ex Order 26, 4B1 I Give NJ Ex Orde, with an order date of NJ Ex Order 26, 4B A review of the resident's eMAR revealed the same orders scheduled at 9:00 AM and 5:00 PM and documented as being given at those times. The eMAR also reflected that the NJ Ex Order 26, 4B1 was discontinued and not given as of NJ Ex Order 26, 4 after surveyor's inquiry. S #2 reviewed the CP reports for Resident #48. The reports revealed on NJ Ex Order 26.4(b, the CP made a recommendation to the facility for Resident #48 to change the NJ Ex Order 26, 4B1 order to NJ Ex Order 26, 4B1 as resident needs meds crushed, as the capsules (caps) cannot be crushed. The report also reflected that the facility response was -med changed to liquid form. Further review of the CP reports revealed a CP recommendation dated NJ Ex Order 26.4(, that reflected, NJ Ex Order 26 appeared twice on the eMAR- liquid & caps @ 9 AM and 5 PM. Please confirm both orders and discontinue one order if needed. There was no response documented on the report. On 1/28/26 at 1:47 PM, the survey team met with the U. S. FOIA (b) (2), and S #2 notified them of the above findings and concerns of duplicate meds ordered and the CP's recommendations were not followed. On 1/29/26 at 11:44 AM, the survey team met with the U. S. FOIA (b) (2), and there was no additional information provided by the U. S. FOIA (b) A review of the facility's "Pharmacy Services Policy", dated revised 9/1/25, the policy did not reflect any mention of the facility responding to or acting on CP recommendations or any time frame to do so. NJAC 8:39-29.3(a)(1)	F0756		02/02/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General.	F0757	Resident 15 was affected by this deficient practice. Upon notification education was provided by U. S. FOIA (b) (2) to nurse on dosage and administration of NJ Ex Order 26, 4B1 .	02/02/2026

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 01/29/2026

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COMPLETE CARE AT PROSPECT HEIGHTS LLC	**336 PROSPECT AVE , HACKENSACK, New Jersey, 07601**

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F0757 SS = D	Continued from page 73 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that the resident (Resident #15) did not receive an unnecessary medication by inaccurate or unknown dose for 1 of 5 residents, (Resident #15), reviewed for unnecessary medications. The deficient practice was evidenced by the following: The surveyor reviewed Resident #15's electronic medical record (EMR) which revealed the following: A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to: NJ Ex Order 26, 4B1 [redacted] A review of Resident #15's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an	F0757	Continued from page 73 All residents with orders for diclofenac external sodium gel have the potential to be affected by this deficient practice. Audit conducted to ensure all residents with orders for diclofenac sodium external gel had dosage cards and nurses were educated on dosing and how to apply medication. Assistant Director of Nursing educated nurses on dosing and application of NJ Ex Order 26, 4B1 [redacted] Director of Nursing / designee will conduct an audit of all residents utilizing diclofenac sodium external gel and observe 3 residents weekly x 3 weeks and monthly x 2 months who are receiving this medication to ensure nurse is administering correctly. The results of the audits will be reviewed in the monthly Quality Assurance Performance Improvement meetings. Date of Completion: 01/29/2026	02/02/2026

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F0757 SS = D	Continued from page 74 assessment reference date (ARD) of [redacted] had a Brief Interview for Mental Status (BIMS) score of [redacted], which indicated the resident has [redacted] A review of the resident's Comprehensive Care Plan (CCP), dated [redacted], which reflected that the resident [redacted] A review of the Order Summary Report (OSR), reflected the following active physician orders (PO) as of [redacted], which reflected the following medication (med) orders: [redacted] Apply to [redacted]. [redacted] Apply to [redacted] A review of the resident's electronic medication administration (eMAR) revealed the following orders that matched the OSR. [redacted] Apply to [redacted] -Order Date-[redacted] [redacted] Apply [redacted] -Order Date [redacted] On 1/22/26 at 9:54 AM, the surveyor interviewed the resident and the surveyor asked the resident how they get the [redacted] from the staff. The resident stated that the nurse comes in with it in a small cup. On 1/22/26 at 10:06 AM, the surveyor interviewed the [redacted] who was assigned to care for Resident #15 that day. The surveyor asked the [redacted] how they administered the [redacted] and how they know how much was used. The [redacted] stated it depends on the [redacted] Some residents get [redacted] for [redacted] and some need more if there was a [redacted]. The [redacted] further stated, "Maybe" the size of [redacted] The [redacted] did not state any amount or a dose.	F0757		02/02/2026

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F0757 SS = D	Continued from page 75 On 1/28/26 at 1:47 PM the survey team met with the U. S. FOIA (b) (2) and the surveyor notified them of the above findings and concerns. On 1/28/26 at 3:00 PM, the surveyor contacted the facility U. S. FOIA (b) (2)) by phone and the surveyor asked the U. S. FOIA how NJ Ex Order 26, 4B1 was given and if there was a dose that was used. The U. S. F stated that the dose was either NJ Ex Order 26, 4B1 measured on a dose card that comes with the product, depending on where it was going to be applied. The surveyor reviewed the manufacturer package insert NJ Ex Order 26, 4B1, otherwise known as NJ Ex Order 26, 4B1. The NJ E reflected under Dosage and Administration: NJ Ex Order 26, 4B1 should be measured onto the enclosed dosing card to the appropriate NJ Ex Order 26, 4B1 designation. NJ Ex Order 26, 4B1: apply NJ Ex Order 26, 4B. NJ Ex Order 26, 4B1 apply NJ Ex Order 26, 4B. On 1/29/26 at 11:44 AM, the survey team met with the U. S. FOIA (b) (2), and there were no further information provided by the U. S. FOIA (b) (2). A review of the facility's "Medication Administration Policy", Reviewed/Revised date of 9/1/2025, the policy reflected, under 10. c. Right Dosage, 12. Compare med…to verify…dose… a. Refer to drug reference material if unfamiliar with the med. NJAC 8:39-27.1(a)	F0757		02/02/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761	No residents were affected by this deficient practice. Upon notification LPN 1 was educated on ensuring medications are not left on top of the medication cart when left unattended and LPN 2 was educated on ensuring only medications in active use remain in the medication cart by the Director of Nursing. All residents have the potential to be affected by this deficient practice. All medication carts audited to ensure no medications where left unattended and no medications that were not in use were stored inside medication carts. Assistant Director of Nursing educated all nurses on	02/02/2026

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F0761 SS = D	Continued from page 76 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store and/or label medication per manufacturer specifications and standards of practice. This deficient practice was identified in 1 of 2 medication carts (med cart) observed during the medication pass (med pass) observation and 1 of 5 med carts observed during the med storage observation. 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 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 1/23/26 at 9:05 AM, the surveyor observed Licensed Practical Nurse #1 (LPN #1) assigned to the [redacted] floor [redacted] prepare and administer medications (meds) to Resident #114. The surveyor observed LPN #1 entered the resident's room to administer due meds and leave a bottle of Aspirin 81 mg (milligram) chewable tablets (tabs) unattended on top of the med cart. On the same day at 9:47 AM, the surveyor observed	F0761	Continued from page 76 ensuring no medications are left unattended and that no medication that are not active are stored inside the medication carts. Director of Nursing or designee will conduct an audit of 3 carts weekly x 4 weeks and monthly x 2 months to ensure no medications are on top of cart when not attended and that no medications that are not in active use are being stored inside the medication cart. Results of the audit will be presented at the monthly Quality Assurance Performance Improvement Meetings. Date of Completion: 01/29/2026	02/02/2026

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F0761 SS = D	Continued from page 77 LPN #1 prepare and administer meds to Resident #131. The surveyor observed LPN #1 entered the resident's room to administer due meds and leave a package containing methylprednisolone (Medrol, a steroid med used for swelling) tablets (tabs), unattended on top of the med cart covered by a sheet of paper. The surveyor concluded the observation. On 1/28/26 at 11:19 AM, the surveyor observed the med cart located on the [redacted] floor, in the bottom drawer, a plastic bag containing a [redacted]. The surveyor observed that the [redacted] had a resident's name and a date written on it in black marker ink. The surveyor also observed that the [redacted] did not have any labeling affixed by the facility provider pharmacy or other pharmacy. The surveyor asked Licensed Practical Nurse #2 (LPN #2) assigned to the med cart whose [redacted] it was and why it was in the med cart without a label. LPN #2 stated that it belonged to Resident #41, and was probably brought from the hospital or from home. The surveyor asked LPN #2 what the date written on the [redacted] meant. LPN #2 stated that the resident told us when it was opened. The surveyor also observed another [redacted] in the med cart in a manufacturer box with a pharmacy label and a pharmacy label on the [redacted] itself. The labels reflected that the [redacted] was for Resident #41. The surveyor asked LPN #2 which [redacted] was being used and how would staff know which one to use. LPN #2 stated that the [redacted] from the provider pharmacy was used and the other [redacted] was just kept there but can be disposed of if needed. The surveyor concluded the observation. On 1/28/26 at 1:47 PM the survey team met with the [redacted] to inform of concerns. The surveyor notified the [redacted] of the concerns with storage of medications (meds), meds being left unattended and unlabeled [redacted]. The [redacted] responded that the [redacted] was resident property and that the facility wanted to keep it secure. The surveyor stated that the med cart contained active in-use meds and asked if there would be any other place to store it. The [redacted] stated that the med cart was always locked and the best	F0761		02/02/2026

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F0761 SS = D	Continued from page 78 place. On 1/28/26 at 3:00 PM, the surveyor contacted the facility U. S. FOIA (b) (2) by phone. The surveyor asked the U. S. FO if meds should be left on top of the med cart and if meds should have proper labels from the pharmacy. The U. S. FO stated that meds should not be left on top of the med cart and meds should have proper labels or removed from the active meds and stored elsewhere such as the med room. On 1/29/26 at 11:44 AM, the survey team met with the U. S. FOIA (b) (2) for responses to concerns. The U. S. FOIA (b) (2) had nothing further regarding the med storage concerns. A review of the facility's "Medication Storage Policy", dated reviewed/revised 9/1/25, the policy reflected under General Guidelines: All drugs and biologicals will be stored in locked compartments… The policy did not reflect anything relating to labeling of meds. NJAC 8:39-29.4(d)(g)	F0761		02/02/2026
F0908 SS = D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and policy review, it was determined that the facility failed to maintain essential kitchen equipment in safe operating condition for 2 of 2 days of observation. This deficient practice was evidenced by the following: On 1/21/26 at 9:45 AM, in the presence of the U. S. FOIA , the surveyor observed a leaking sink located in the middle of the food preparation area. The U. S. FOIA was unable to turn off the sink with the faucet handles. The U. S. FOIA stated she did not know about the leaking sink and stated, "I will	F0908	No residents were affected by this deficient practice. Upon notification leak was addressed and fixed by maintenance. All residents have the potential to be affected by this deficient practice. Administrator educated U.S. FOIA (b)(6) on ensuring equipment is in safe and working condition. Food service director designee will conduct and audit weekly x 4 weeks and then monthly x 2 months to ensure sink is in working condition. Results will be reviewed at the quarterly QAPI meetings.	02/02/2026

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 01/29/2026

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
F0908 SS = D	Continued from page 79 have them come check". On 1/22/26 during a follow-up kitchen tour, the surveyor observed that the sink in the meal prep area continued to have a steady leak ongoing. A review of the facility's "Kitchen cleaning policy" dated 9/1/25, revealed, the policy indicated that the staff shall maintain the sanitation of the kitchen. During an interview on 1/22/26 at 2:00 PM, the surveyor brought the above concerns to the attention of the U. S. FOIA (b) (2) [redacted] On 1/29/26 at 1:50 PM, the survey team met with the U. S. FOIA (b) (2) and U. S. FOIA (b) (2) [redacted] for exit conference, and there was no additional information provided by the U. S. FOIA (b) [redacted] NJAC 8:39-31.2(e)	F0908		02/02/2026

New Jersey 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 01/29/2026

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
H0000	Initials Comments A Recertification Survey was conducted, and it was determined that the facility was not in compliance with the requirements under N.J.A.C. 8:43 E General Licensure Procedures And Standards Applicable To All Licensed Facilities.	H0000		01/29/2026
S0000	Initial Comments The facility is 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		01/29/2026
H5790	UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM CFR(s): 8:43E-13.4(d) A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interviews, review of the medical records, and other facility documentation, it was determined that the facility failed to maintain a copy of the New Jersey Universal Transfer Form (UTF) as part of the medical record for 1 of 3 residents reviewed for NJ Ex Order 26.4(b)(1) (Resident #67). This deficient practice was evidenced by the following: Reference: New Jersey Administrative Code 8:43 E General Licensure Procedures and Standards: Section 8:43E-13.4 - Mandatory use of Universal	H5790	1. Upon identifying that Resident #67's medical record did not contain a copy of the universal transfer form completed during the NJ Ex Orde transfer to the hospital, the facility educator in serviced all nurses, reinforcing the requirement for completing and uploading the universal transfer form for all transfers to the NJ Ex Order 26.4(b)(1). 2. All residents who are transferred to the emergency room have the potential to be affected by this deficient practice. 3. Assistant Director of Nursing / Designee educated nurses on the completion and uploading of the Universal Transfer Form upon discharge to the emergency department. 4. Director of Nursing / Designee will audit all transfers to the hospital weekly x 4 weeks to ensure transfers to the emergency department have universal transfer forms completed and uploaded then monthly x 2 months. Results of the audits will be reviewed at the monthly Quality Assurance Performance Improvement Meeting. Date of Completion: 01/29/2026	02/02/2026

Office of Primary Care and Health Systems Management

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 01/29/2026

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

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H5790	Continued from page 1 Transfer Form (a) A licensed healthcare facility or program shall use the UTF, HFEL-7, provided as N.J.A.C. 8:43E-13 Appendix, incorporated herein by reference, and available on the Department's website at http://web.doh.state.nj.us/apps2/forms/, in either paper or electronic version, whenever a patient is transferred to another licensed healthcare facility or program. 1. Emergency departments are exempt from mandatory use of the UTF, but shall follow hospital procedures regarding documentation. (b) A licensed healthcare facility or program shall complete all sections of the UTF, to the best of the licensed healthcare facility or program's ability. 1. The UTF is not complete if medication information is not attached. (c) A licensed healthcare facility or program shall send a completed, paper copy of the UTF with a patient when a patient is transferred. (d) A licensed healthcare facility or program shall retain a completed copy of the UTF sent with a patient when a patient is transferred as part of the patient's medical record. On 1/22/26 at 11:49 AM, the surveyor reviewed Resident #67's closed electronic medical record. A review of the Admission Record (an admission summary) or face sheet revealed that Resident #67 was admitted to the facility with diagnoses that included but were not limited to; NJ Ex Order 26, 4B1 [redacted] A review of the most recent comprehensive MDS, with an Assessment Reference Date (ARD) of NJ Ex Order 26 [redacted], reflected that Resident #67 had a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26, 4B [redacted], indicated NJ Ex Order 26, 4B1 Further review of the MDS revealed that the resident had most recent unplanned transfer to the NJ Ex Order 26,4	H5790		02/02/2026

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 01/29/2026

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H5790	Continued from page 2 A review of the Progress Notes with an effective date of 8/27/25 at 5:59 AM, that was electronically signed by the Registered Nurse (RN), reflected that STAT (a common medical abbreviation that means immediately or without delay. It comes from the Latin word statim, which translates to “at once.”) laboratory results were reported to the physician at 3:30 AM, the physician ordered the resident to be transferred out to [NJ Ex Order 26.4(b)(1)], and the resident was picked up by [NJ Ex Order 26.4(b)(1)] at 4:05 AM. Further review of the medical records revealed there was no documented evidence that the UTF was done, and a copy was left on file. On 1/28/26 at 10:14 AM, the surveyor interviewed the Director of Nursing (DON). The DON confirmed and stated everything in the electronic file for resident's medical records or if there were paper records they would be shredded because “we” do not keep paper files. The surveyor asked what the expectation for resident was transferred to hospital, with regard to UTF, and the DON stated that "we" do UTF and upload in the miscellaneous (misc) tab when resident went to [NJ Ex Order 26.4(b)(1)]. At that time, the surveyor notified the DON of the above concern that there was no UTF when the resident was transferred to [NJ Ex Order 26.4(b)(1)] due to laboratory results, and the DON stated there should be a UTF and she did not know why there was no UTF done. On 1/28/26 at 1:47 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and DON, and the surveyor notified them of the above findings and concerns with Resident #67’s UTF. On 1/29/26 at 11:43 AM, the survey team met with the LNHA and DON. The DON stated that the facility had no policy with regard to UTF. On 1/29/26 at 1:50 PM, the survey team met with the LNHA, DON and Vice President of Clinical Services for exit conference, and there was no additional information provided by the LNHA.	H5790		02/02/2026

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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: REPEAT DEFICIENCY Complaint NJ#s: 384182, 384183, 384186, 384188, 2573473, 2615149, and 2668945 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey, for 31 of 35 day shifts, 10 of 28 evening shifts, and 5 of 7 night shifts. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide	S0560	No Residents were affected by this deficient practice All Residents have the potential to be affected by this deficient practice. Additional per diem, part time and fulltime were scheduled to meet minimum staff to resident ratios. Licenses/ certifications were verified by the Human Resources Director / Staffing Coordinator for current licensed certified staff. Director of Nursing / designee in-serviced Human Resources Director / Staffing Coordinator on appropriate staffing levels. The facility has advertised open jobs through online recruitment platforms as well as traditional recruitment firms. The facility has conducted job fairs and has contracts with nursing staffing agencies. The Human Resources Director / Staffing Coordinator or designee will audit weekly x4 weeks and monthly x2 months to ensure staffing levels are within the mandated ratios. All identified concerns will be corrected immediately. The results of the audits will be reviewed in Quality Assurance Performance Improvement meetings monthly. Date of Completion: 01/29/2026	02/02/2026

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 01/29/2026

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S0560	Continued from page 4 duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 7 weeks of staffing in 6 segments by dates and the 2 weeks of staffing for the 01/29/2026 Standard survey with Complaints revealed the following: For the 7 weeks of staffing, the facility was deficient as follows: 1.For the week of Complaint staffing from 02/23/2025 to 03/01/2025, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -02/23/25 had 9 CNAs for 108 residents on the day shift, required at least 13 CNAs. -02/24/25 had 11 CNAs for 107 residents on the day shift, required at least 13 CNAs. -02/25/25 had 9 CNAs for 105 residents on the day shift, required at least 13 CNAs.	S0560		02/02/2026

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S0560	Continued from page 5 -02/27/25 had 10 CNAs for 102 residents on the day shift, required at least 13 CNAs. -03/01/25 had 10 CNAs for 99 residents on the day shift, required at least 12 CNAs. 2.For the week of Complaint staffing from 05/25/2025 to 05/31/2025, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -05/25/25 had 7 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/26/25 had 11 CNAs for 111 residents on the day shift, required at least 14 CNAs. -05/27/25 had 10 CNAs for 108 residents on the day shift, required at least 13 CNAs. -05/28/25 had 12 CNAs for 108 residents on the day shift, required at least 13 CNAs. -05/31/25 had 10 CNAs for 107 residents on the day shift, required at least 13 CNAs. 3.For the week of Complaint staffing from 07/27/2025 to 08/02/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 5 of 7 evening shifts as follows: -07/27/25 had 8 CNAs for 119 residents on the day shift, required at least 15 CNAs. -07/27/25 had 5 CNAs to 14 total staff on the evening shift, required at least 7 CNAs. -07/28/25 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -07/29/25 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -07/29/25 had 6 CNAs to 15 total staff on the evening shift, required at least 7 CNAs. -07/30/25 had 10 CNAs for 119 residents on the day shift, required at least 15 CNAs. -07/30/25 had 8 CNAs to 18 total staff on the evening shift, required at least 9 CNAs. -07/31/25 had 11 CNAs for 119 residents on the day	S0560		02/02/2026

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 01/29/2026

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S0560	Continued from page 6 shift, required at least 15 CNAs. -08/01/25 had 10 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/01/25 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -08/02/25 had 7 CNAs for 121 residents on the day shift, required at least 15 CNAs. -08/02/25 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. 4.For the week of Complaint staffing from 08/31/2025 to 09/06/2025, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts, deficient in total staff for residents on 1 of 7 evening shifts and deficient in CNAs to total staff on 5 of 7 evening shifts as follows: -08/31/25 had 4 CNAs for 123 residents on the day shift, required at least 15 CNAs. -08/31/25 had 10 total staff for 123 residents on the evening shift, required at least 12 total staff. -08/31/25 had 3 CNAs to 10 total staff on the evening shift, required at least 5 CNAs. -09/01/25 had 6 CNAs for 123 residents on the day shift, required at least 15 CNAs. -09/02/25 had 9 CNAs for 121 residents on the day shift, required at least 15 CNAs. -09/02/25 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -09/03/25 had 8 CNAs for 121 residents on the day shift, required at least 15 CNAs. -09/03/25 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. -09/04/25 had 9 CNAs for 120 residents on the day shift, required at least 15 CNAs. -09/05/25 had 9 CNAs for 117 residents on the day shift, required at least 15 CNAs. -09/05/25 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. -09/06/25 had 7 CNAs for 117 residents on the day shift, required at least 15 CNAs.	S0560		02/02/2026

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S0560	Continued from page 7 -09/06/25 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. 5.For the 2 weeks of staffing prior to survey from 01/04/2026 to 01/17/2026, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in CNAs to total staff on 4 of 14 evening shifts as follows: -01/04/26 had 7 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/04/26 had 7 CNAs to 16 total staff on the evening shift, required at least 8 CNAs. -01/05/26 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/06/26 had 9 CNAs for 116 residents on the day shift, required at least 14 CNAs. -01/07/26 had 8 CNAs for 115 residents on the day shift, required at least 14 CNAs. -01/08/26 had 10 CNAs for 113 residents on the day shift, required at least 14 CNAs. -01/09/26 had 9 CNAs for 112 residents on the day shift, required at least 14 CNAs. -01/09/26 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs. -01/10/26 had 8 CNAs for 110 residents on the day shift, required at least 14 CNAs. -01/11/26 had 7 CNAs for 108 residents on the day shift, required at least 13 CNAs. -01/12/26 had 7 CNAs for 107 residents on the day shift, required at least 13 CNAs. -01/13/26 had 8 CNAs for 107 residents on the day shift, required at least 13 CNAs. -01/14/26 had 9 CNAs for 107 residents on the day shift, required at least 13 CNAs. -01/15/26 had 7 CNAs for 107 residents on the day shift, required at least 13 CNAs. -01/16/26 had 7 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/16/26 had 6 CNAs to 17 total staff on the	S0560		02/02/2026

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 01/29/2026

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S0560	Continued from page 8 evening shift, required at least 8 CNAs. -01/17/26 had 8 CNAs for 117 residents on the day shift, required at least 15 CNAs. -01/17/26 had 7 CNAs to 17 total staff on the evening shift, required at least 8 CNAs. On 1/21/26 at 10:14 AM, the surveyor interviewed the 5th floor Registered Nurse/Unit Manager (RN/UM). The surveyor asked if she knew the regulation for CNA and resident ratio, and she replied, "The ratio for 7 AM-3 PM shift is 1 CNA to 14 residents (1:14). I'm not too sure". On 1/22/26 at 10:06 AM, the surveyor interviewed the 6th floor RN/UM, who stated that "usually three CNAs, they always say it was too much", and each one (CNA) had 15 residents in their assignments, and they still able to get everything done. The RN/UM was unsure of the CNA to Resident ratio. The RN/UM further stated that it was the Staffing Coordinator who was responsible for staffing. She further stated that the facility did not utilize agency for short staff and that she did not know why. On 1/22/26 at 10:15 AM, the surveyor interviewed the 6th floor CNA who stated that they were short staff in the weekends, sometimes there were two CNAs on 7 AM-3 PM shift. The CNA further stated "I just don't take my breaks". The CNA also stated that "I" finish everything but not the way I would like to. The CNA added that "I have 14 patients today". At that same time, the CNA informed the surveyor that they did not use agency, and "I'm not sure why". The CNA further stated "I heard" the regulation was 1:8 ratio. On 1/23/26 at 9:34 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated that she staff the floor based on the census and that she was responsible for staffing in the facility. The SC further stated "I am" aware of the regulation, 7-3 shift 1 CNA:8 Residents, 3-11 shift 1:10, and 3-11 shift 1:14. The SC confirmed that "We don't use agency" for staffing per LNHA. The SC also stated that the facility was not able to met the regulation for staffing ratio for some part and that included the weekends.	S0560		02/02/2026

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COMPLETE CARE AT PROSPECT HEIGHTS LLC	**336 PROSPECT AVE , HACKENSACK, New Jersey, 07601**

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S0560	Continued from page 9 On 1/29/26 at 1:50 PM, the LNHA, DON, and the Vice President of Clinical Services were notified of above concerns with staffing. A review of the facility's "Staffing Policy" dated 9/1/25, revealed under Policy Statement, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans... The State regulation for CNA staffing ratio was not included in their facility policy.	S0560		02/02/2026
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of employee files and health records, it was determined that the facility failed to ensure that a newly hired employee completed a health history and received an examination by a physician, an advanced practice nurse, or a licensed physician assistant within two weeks prior to the first day of employment or upon employment for 4 of 42 (Staff #1, #2, #3, and #4) of new employee files reviewed. This deficient practice was evidenced by the following: On 1/21/26 at 2:30 PM, the License Nursing Home Administrator (LNHA) provided the new hires list, which revealed 42 new staff total.	S1405	No residents were affected by this deficient practice. At the time of notification Infection Preventionist and Human Resources Director educated by Administrator on completion of new hire employee physician health examination prior to hire. If physical health examination is completed prior to hire, Physician or Nurse Practitioner examination must be within 30 days. All residents have the potential to be affected by this deficient practice. All health files reviewed with no further findings. Administrator educated Human Resources Director and Infection Preventionist on completion of physician health examination prior to hire and if physical health examination is completed prior to hire Physician or Nurse Practitioner examination must be within 30 days. Administrator or designee will conduct and audit weekly x 4 weeks and then monthly x 2 months to ensure all new employee physicals are completed timely. The results of the audit will be discussed at the monthly Quality Assurance Performance Improvement Meetings. Date of Completion: 01/29/2026	02/02/2026

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 01/29/2026

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
S1405	Continued from page 10 The surveyor reviewed 42 newly hired employee files from the most recent annual re-certification. The review of the physical examinations for 4 of the 42 new employees revealed the following: 1. Staff #1, Certified Nursing Assistant (CNA): Date of Hire (doh) was [redacted]. The initial nursing assessment was completed by a Registered Nurse (RN) on 11/18/24, and the physician's health examination was completed on 11/19/24 (after the doh). 2. Staff #2, maintenance staff: doh was [redacted] The RN initial nursing assessment was completed on 1/23/25, and the physician health examination completed on 1/23/25 (after doh). 3. Staff #3, RN: doh was [redacted] The RN initial nursing assessment was completed on 2/5/25, and the physician health examination completed on 3/27/25 (NJ Ex Order 26.4(b)(1) from doh). 4. Staff #4, License Practical Nurse (LPN): doh was [redacted]. The RN initial nursing assessment was completed on 4/3/25,and the physician health examination was completed on 4/29/25 (after doh). On 1/29/26 at 10:57 AM, the surveyor interviewed the Human Resources (HR) Director and asked what was the facility's process for new hires, and HR Director replies that the Infection Preventionist Nurse (IPN) was responsible for health files of new employees in the hiring process. On 1/29/26 at 11:03 AM, the surveyor interviewed the IPN who stated the she was responsible for health files of new employees and that she go over their health history. The IPN also stated that the health screening was done by the Nurse Practitioner (NP) and done before the doh. The IPN further stated that "We have a couple of weeks to do it". She added that the Physician "does the examination asap (as soon as possible)". The IPN stated "We have four weeks to get it done from doh, but we mostly get it earlier". At that same time, the surveyor asked the IPN if she was aware of the regulation with new hires health history and physical examination, and the IPN responded that she would get back to the surveyor.	S1405		02/02/2026

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 01/29/2026

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

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S1405	Continued from page 11 On 1/29/26 at 12:19 PM, the survey team met with the LNHA and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. The LNHA stated he was aware of the regulation, "Practice is two weeks before hire and 30 days after doh". On 1/29/26 at 12:53 PM, the LNHA stated, "I verified it (physical), it was not within 30 days". A review of the facility's "Employee Physical Policy" dated 9/1/25, revealed under Policy Interpretation and Implementation #3,…examinations shall also be used to screen employees for signs, symptoms, and/or risk factors for communicable diseases... The policy did not include the timeframe of the State requirement of newly hired employee examination by a physician, an advanced practice nurse, or a licensed physician assistant within two weeks prior to the first day of employment or upon employment.	S1405		02/02/2026

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 03/18/2026

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

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F0000	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 03/18/2026 in relation to the 01/29/2026 Recertification 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 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 03/18/2026

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

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H0000	Initials Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/18/2026 in relation to the 01/29/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code for Long Term Care Facilities.	H0000		
S0000	Initial Comments An offsite/desk review of the facility's Plan of Correction was conducted on 03/18/2026 in relation to the 01/29/2026 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315460	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

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

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K0000 Bldg. 01	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/23/26 and the facility 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 Occupancies. Complete Care at Prospect Park is a seven-story building with a four-level parking garage underneath that built in 1999. Resident rooms were located on floors three through six. It is composed of Type I protected construction. The facility is divided into 12-smoke zones. The 500 KW diesel generator powers approximately 80% of the building per the U. S. FOIA (b) (2) The number of occupied beds was 68 of 103.	K0000		01/23/2026
K0353 SS = F Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K0353	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: Upon notification, the sprinkler head behind the laundry dryers in the main laundry area of the service corridor was cleaned and the lint removed on 1/23/2026. The upright sprinkler in the service corridor of the mechanical room that was corroded with patina was replaced on 2/5/2026. Measures or systemic changes to ensure that the deficiency will not recur:	02/05/2026

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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: 315460	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING	(X3) DATE SURVEY COMPLETED 01/28/2026

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

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K0353 SS = F Bldg. 01	Continued from page 1 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to ensure sprinklers were free of physical damage or foreign materials for two of 13 sprinklers in the service areas in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition) Section 5.2.1.1.1. This deficient practice had the potential to affect all 68 residents and was evidenced by the following: An observation on 01/23/26 at 12:59 PM behind the laundry dryers in the main laundry area of the service corridor, revealed one upright sprinkler above the dryers was loaded with lint. An observation on 01/23/26 at 1:09 PM of the mechanical room it was revealed one upright sprinkler in the service corridor was corroded with patina. During an interview at the time of the observations, the U. S. FOIA (b) (2) confirmed that the sprinkler in the laundry room was loaded with lint and that the sprinkler in the mechanical room was corroded with patina. NJAC 8:39-31.1(c), 31.2(e) NFPA 13, 25	K0353	Continued from page 1 Administrator educated Maintenance Staff on preventive maintenance to ensure all sprinkler heads remain clean and free from debris. Environmental Services Director will inspect 10 sprinkler heads weekly x 4 weeks and then monthly x 2 months to ensure they are clean and free of debris. The results of the audits will be presented at the quarterly Quality Assurance and Performance Improvement Meetings. Recommendations will be reviewed submitted quarterly to The Quality Assurance Performance Improvement (QAPI)Committee, chaired by the Administrator. Date of Completion: 02/05/2026	02/05/2026
K0374 SS = E Bldg. 01	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in	K0374	Identify those individuals who could be affected by the deficient practice: All residents on NJ Ex 6 Floor have the potential to be affected by the deficient practice. What corrective action will be accomplished for those residents affected by the deficient practice: Upon notification the smoke barrier door was immediately adjusted to ensure there are no gaps.	01/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315460	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **01/28/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0374 SS = E Bldg. 01	Continued from page 2 the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure smoke barrier doors closed when released from hold open devices in accordance with NFPA 101, Life Safety Code (2012 Edition) Section 19.3.7.8. This deficient practice had the potential to affect all 25 residents who resided on wing 455 of the facility and was evidenced by the following: An observation on 01/23/26 at 2:05 PM revealed the fourth floor cross-corridor smoke barrier doors near room [redacted] in corridor [redacted] would not close when released by hand from the magnetic hold open devices. The cross-corridor doors were ajar leaving a one-half inch gap at the top of the doors and thus did not prevent the passage of smoke. During an interview at the time of the observations, the U. S. FOIA (b) (2) confirmed corridor door would not close when released. NJAC 8:39-31.1(c), 31.2(e)	K0374	Continued from page 2 Measures or systemic changes to ensure that the deficiency will not recur: All doors in smoke barriers were inspected to ensure there were no gaps when closed. Administrator educated Maintenance Staff on routine inspections of smoke barrier doors to ensure there are no gaps when doors are closed. Environmental Services Director will inspect all smoke barrier doors weekly x 4 weeks then monthly x 2 months to ensure there are no gaps when fire doors are closed. The results of the audits will be presented at the quarterly Quality Assurance and Performance Improvement Meetings. Recommendations will be reviewed submitted quarterly to The Quality Assurance Performance Improvement (QAPI)Committee, chaired by the Administrator. Date of Completion: 01/23/2026	01/28/2026

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 01/28/2026

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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) on 01/23/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		01/23/2026

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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: 315460	(X2) MULTIPLE CONSTRUCTION A. BUILDING **01 - MAIN BUILD...** B. WING	(X3) DATE SURVEY COMPLETED **04/12/2026**

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 4/12/2026 in relation to the 1/28/2026 Life Safety Code survey. The facility was found to be in compliance 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.	K0000		

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