STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING _____ B. WING _____	C 09/27/2024

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

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F 000	INITIAL COMMENTS	F 000		

Complaint #'s: NJ00166884, NJ00170399, NJ00172105, NJ00174237, NJ00177137, NJ00169244, NJ00176606 and NJ00162439

Survey Dates: 09/23/24 through 09/27/24
Survey Census: 96
Sample Size: 50

A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B requirements for Long Term Care Facilities.

During the survey a finding which constitued Immediate Jeopardy (IJ) was idenified under 42 CFR 483.80 F 880 as the facility failed to ensure that multi-use glucometers were disinfected with an approved Enviornmental Protection Agency (EPA) disinfectant between resident use.

On 09/26/24 at 5:02 PM, the U.S. FOIA (b)(6) [redacted]), Regional Nurse Consultant (RNC) #1, and Regional Nurse Consultant (RNC) #2 were notified of Immediate Jeopardy (IJ) in the following area: F 880-K: Infection Control. The IJs began on 09/24/24, when one (1) of two (2) Licensed Practical Nurses on two (2) of the four (4) units were observed using an alcohol wipe to clean the glucometer after use on a resident. The failure to disinfect NJ Ex Order 26.4(b)(1) with an appropriate disinfectant increased the likelihood of transmission of NJ Exec Order 26.4b1

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

Electronically Signed | 10/17/2024

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

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F 000	Continued From page 1 The U.S. FOIA (b) (6) was informed of the Immediate Jeopardy and was provided with the Immediate Jeopardy template on 09/26/2024 at 5:02 PM. On 09/27/2024, the facility submitted a removal plan indicating the immediate action that the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan relative to F 880 to remediate the deficient practice including facility wide staff education regarding on proper disinfection of multi-use glucometers. The facility provided an acceptable removal plan for of the Immediate Jeopardy on 09/27/24 at 4:46 PM. The survey team validated the IJ was removed on 09/27/24 at 5:10 PM, following the facility's implementation of the removal plan.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of eight Residents (Resident (R) 9) has the appropriate physician orders in place for the use of NJ Exec Order 26 NJ Exec Or as well as ensure NJ Exec Order 26.4b1 was properly labeled.	F 695	Residents affected by deficient practice: The facility staff failed to have active order for NJ Exec Order 26.4 use, as well as proper labeling of NJ Exec Order 26.4b1 for One (1) of Eight (8) residents in the survey sample (Resident (R)9).	11/7/24

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F 695	Continued From page 2 Findings include: Record review of the electronic medical record (EMR) for R9 under the "Orders" tab revealed no active order for [NJ Exec Order 26.4b] use. Observation on 09/23/24 at 12:09 PM revealed R9 bed resting with [NJ Exec] in use at NJ Ex Order 26.4(b)(1) from a NJ Exec Order 26.4b1 . In addition, there was no labeling on the [NJ Exec Order 26.4b] delivery system being used, ([NJ Ex Order 26] or NJ Ex Order 26.4(b)(1) unlabeled). Observation on 09/24/24 at 10:03 AM, revealed R9 was observed in her room with family at bedside [NJ Ex Order] [NJ Exec Order 26.4b1] and NJ Exec Order 26.4b1 remains unlabeled. In addition, the [NJ Exec Order 26.4b1] is observed wrapped around the side rail of the resident's bed and other [NJ Exec] [NJ Ex Order] is on the bedside table uncovered, dangling to the floor. A staff nurse came in and gave R9 a med and walked right out without addressing the [NJ Exec] . Interview on 09/24/24 at 10:27 AM with Licensed Practical Nurse (LPN) 3 confirmed that the [NJ Exec] should be on continuously by NJ Ex Order 26.4(b)(1) and that the NJ Exec Order 26.4b1 is not properly labeled to show that it was changed weekly. LPN3 confirmed that dangling [NJ Ex Order 26] is contaminated. She says she will be changing the entire [NJ Exec] for this Resident immediately. Observation on 09/25/24 at 3:35 PM revealed R9 in bed with NJ Exec Order 26.4b1 with labeling to [NJ Exec Order 26.4b1] [NJ Ex Order 26.4(b)] system. Interview on 09/25/24 at 4:45 PM with LPN9	F 695	Identify those individuals who could be affected by the deficient practice: * All residents have the potential to be affected by the deficient practice. * The affected resident order was reviewed, as well as proper labeling of oxygen tubing and remediation completed. What corrective action will be accomplished for those residents affected by the deficient practice: * Resident #9's [NJ Ex Order 26.4] order was immediately reviewed for active status. * Resident #9's NJ Ex Order 26.4(b)(1) was immediately labeled. * All nursing staff re-educated on importance of following orders as written and calling Physician with a resident change in condition for order(s) that have become discontinued. In addition, nursing staff re-educated on oxygen implementation, setting, labeling and documentation. Measures or systemic changes to ensure that the deficiency will not recur: The Director of Nursing/Unit Manger/Designee will conduct audits of 8 random residents on oxygen implementation, setting, labeling and orders. Audits will be completed weekly X 4 weeks. Results of audit process will be reviewed at the Quarterly QAPI Meeting x2 quarters to ensure compliance and reassessed for further action.	

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F 695	Continued From page 3 confirmed that R9 did not have any active [NJ Exec] orders, and that the last active order for [NJ Exec] was on [NJ Exec Order 26.4b]. She says the order must have fallen off and needs to be renewed by calling the physician.	F 695	Date of Completion: 11/7/2024	
F 732 SS=C	NJAC 8:39-27.1(a) Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(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: (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(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(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 and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		11/7/24

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F 732	Continued From page 4 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(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 facility policy review, the facility failed to ensure the "Nursing Home Resident Care Staffing Report" was post where resident could view if they desire. This failure had the potential for residents not to know the resident care staffing levels provided for all 96 residents in the facility. Findings include: Review of the facility policy titled "Nurse Staffing Posting Information," revised date of 08/14/24 indicating, "Policy: It is the policy of this facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time." An observation on 09/25/24 at 10:30 AM revealed no staff posting on the third, fifth and sixth floors where residents lived. During an interview on 09/25/24 at 11:00 AM, the U.S. FOIA (b)(6) was asked where the posting was located. The U.S. FOIA (b)(6) stated, "It should be downstairs on the clerks desk." During an interview on 09/26/24 at 10:58 AM, the U.S. FOIA (b)(6) were asked about the	F 732	Residents affected by deficient practice: The facility failed to have staff posting on the third, fifth and sixth floors where residents live. Nurse Staffing Information was only posted at Reception on ground floor. Identify those individuals who could be affected by the deficient practice: * All residents have the potential to be affected by the deficient practice. * The third, fifth and sixth floors immediately had the nurse staffing information posted and remediation completed. What corrective action will be accomplished for those residents affected by the deficient practice: * All nursing staff and staffing coordinator re-educated on nurse staff posting requirements. Measures or systemic changes to ensure that the deficiency will not recur: The Director of Nursing/Unit Manger/Designee will conduct audits of	

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F 732	Continued From page 5 staff posting and how it is made available to the residents. The [redacted] stated, "It was downstairs and sometimes it was posted in the window next to activities. Both verified it was not on the floors where the residents lived. NJAC 8:39-41.2	F 732	nurse staff postings weekly X 4 weeks. Results of audit process will be reviewed at the Quarterly QAPI Meeting x2 quarters to ensure compliance and reassessed for further action. Date of Completion: 11/7/2024	
F 880 SS=K	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	F 880		11/7/24

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F 880	Continued From page 6 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 880	Residents affected by deficient practice:	

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F 880	Continued From page 7 and policy review, the facility failed to 1.) disinfect a NJ Ex Order 26.4(b)(1) with an EPA (Environmental Protection Agency) registered disinfectant for one (1) of four (4) residents (Resident #14) reviewed for [redacted] monitoring. This deficient practice had the potential to affect four (4) of four (4) residents (R #5, R #14, R #20, and R #297), who had physician's orders for NJ Exec Order 26.4b1 . On 09/24/24, one (1) of two (2) Licensed Practical Nurses on two (2) of the four (4) units was observed using an alcohol wipe to clean the NJ Ex Order 26.4(b)(1) after use on a resident. The failure to disinfect NJ Ex Order 26.4(b)(1) with an appropriate disinfectant increased the likelihood of transmission of NJ Exec Order 26.4b1 . This resulted in an Immediate Jeopardy (IJ) situation. The facility also failed to 2.) ensure staff performed adequate doffing (taking off) of Personal Protective Equipment (PPE) and disposing of it properly to prevent the spread of infection for two (2) of two (2) residents (R#197 and R#198). These failures increased the risk of the spread of infections that had the potential for serious harm and/or death. On 09/26/24 at 5:02 PM, the U.S. FOIA (b)(6) [redacted], Regional Nurse Consultant (RNC) #1, and Regional Nurse Consultant (RNC) #2 were notified of Immediate Jeopardy (IJ) in the following area: F 880-K: Infection Control. The IJ began on 09/24/24, when one (1) of two (2) Licensed Practical Nurses on two (2) of the four (4) units was observed using an alcohol wipe to clean the NJ Ex Order 26.4(b)(1) after use on a resident. The failure to disinfect NJ Ex Order 26.4(b)(1) with an appropriate disinfectant increased the likelihood of transmission of [redacted].	F 880	The facility staff failed to disinfect a NJ Ex Order 26.4(b)(1) with an EPA registered disinfectant for One (1) of the Four (4) residents in the survey sample (Resident (R) 14) and failed to ensure adequate doffing of personal protective equipment to prevent the spread of infection for Two (2) residents in the survey sample (Resident (R) 197 and 198). Identify those individuals who could be affected by the deficient practice: * All residents have the potential to be affected by the deficient practice. * One resident was potentially harmed, No other residents were affected by this deficient practice. Residents on the affected unit did not have any communicable diseases. * All multi-use glucometers on all units were immediately disinfected with an EPA approved disinfectant upon discovery of this deficient practice. * All units were provided with EPA approved disinfectant for multi-use glucometers required as per the manufacturer's instructions. * The identified nurse observed with this deficient practice received 1:1 education on proper disinfection of multi-use glucometers. * All nursing staff on shift immediately received education on proper disinfection of multi-use glucometers by DON or designee(s) and validated with return demonstration. * The facility submitted a removal plan indicating the immediate action that the	

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F 880	Continued From page 8 On 09/27/2024, the facility submitted a removal plan indicating the immediate action that the facility will take to prevent serious harm from occurring or recurring. The facility implemented a corrective action plan to remediate the deficient practice including facility wide staff education on proper disinfection of NJ Ex Order 26.4(b)(1). The facility provided an acceptable removal plan for the Immediate Jeopardy on 09/27/24 at 4:46 PM. The survey team validated the IJ was removed on 09/27/24 at 5:10 PM, following the facility's implementation of the removal plan. Findings include: 1. Review of the facility's policy titled, "Glucometer Disinfection," dated 07/01/24, indicated, "I. The facility will ensure blood glucometer's will be cleaned and disinfected after each use and according to manufacturer s instructions for multi-resident use. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected then the meter will not be used for multiple residents. The glucometer's will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV. Hepatitis C and Hepatitis B virus." Observation of Licensed Practical Nurse (LPN) #1 on 09/24/24 at 11:37 AM, revealed the following: LPN#1 obtained the NJ Exec Order 26.4b1 from the East medication cart and went to R#14's bedside. The LPN#1 placed the meter on R#14's bed as she obtained the NJ Exec Order 26.4b1. Upon completion of the testing, LPN#1 exited R#14's room and placed the NJ Exec Order 26.4b1	F 880	facility took to prevent serious harm from occurring / recur that was validated. * The facility failed to ensure one visitor doffed personal protective equipment (PPE) inside R198's room before exiting room. * All residents on isolation precautions have the potential to be affected by the deficient practice. * The residents affected were assessed for any adverse effects of the deficient practice with none noted. What corrective action will be accomplished for those residents affected by the deficient practice: * Resident affected (Resident (R) 14) and other residents that were potentially affected, physician(s) were made aware. Physician(s) did not order any change to their plan of care. Residents and/or responsible party were made aware of occurrence. * Residents were assessed clinically for signs and symptoms of infection including vital signs, skin on fingers where blood sugars were taken. From a clinical standpoint all affected residents have no clinical signs and symptoms of being harmed from having blood sugar taken. * Multi-use Glucometer Disinfection policy was reviewed and revised. * All licensed nursing staff will use the proper EPA approved disinfectant on multi-use glucometers in between residents. * Verbal education was completed by	

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F 880	Continued From page 9 on the top of the medication cart. The LPN#1 completed documentation in the computer, obtained an alcohol wipe and wiped the NJ Exec Orde [redacted] and her fingertips. The LPN#1 then placed the meter in the drawer of the medication cart and explained they were done performing NJ Exec Order 26.4b1 at this time. Interview with LPN#1 on 09/24/24 at 11:37 AM, confirmed the NJ Exec Order 26.4b1 was cleaned with alcohol before placing in the drawer of the medication cart and ready for the next resident's use. The LPN#1 confirmed there was one NJ Ex Order 26.4(b)(1) available for resident use on the NJ Exec O medication cart and it was to be cleaned and disinfected between resident uses. The LPN#1 stated that she had been educated to disinfect the NJ Exec Order 26.4b1 with an alcohol pad. Interview with the U.S. FOIA (b)(6) [redacted] on 09/26/24 at 3:00 PM, confirmed there were four (4) residents (R #5, R #14, R #20 and R #297) on the NJ Exec Order 26.4b1 hallway that had physician orders for NJ Exec Order 26.4b1 and staff used the same NJ Exec Order 26.4b1 for each of those four residents, placing each resident at risk for exposure to NJ Exec Order 26.4b1 [if the NJ Ex Order 26.4(b [redacted] is not disinfected with the appropriate cleaner between residents]. Review of the electronic medical record (EMR) for R#5 under the "Census" tab revealed an admission date of 05/25/24. Under the "Diagnoses" tab of the EMR, R#5 diagnoses included NJ Exec Order 26.4b1 [redacted] Review of the "Physician's Orders" under the "Orders" tab in the EMR revealed an order for NJ Exec Order 26.4b1 four times a day.	F 880	DON or designee(s) with all licensed nursing staff on proper disinfection of multi-use glucometers and this was validated with return demonstration. * If any licensed nursing staff were not available for immediate education, they received written education on proper disinfection on multi-use glucometer via text or email. Prior to working in facility, they will be validated with return demonstration. * Education and validation will be completed on hire by Nursing Educator or Designee(s) for all licensed nursing staff on the proper disinfection of multi-use glucometers. * EPA approved multi-use glucometer disinfectant is available on all units. * Visitor educated on Policy - Personal Protective Equipment using Gowns with emphasis on correct donning and doffing procedures. * Directed Plan of Correction (DPOC) for Tag F880 completed and Facility engaged services of IP Consultant. In addition, the facility reached out to the QIO, for further support and consultation. * The QAA Committee convened to conduct Root-Cause Analysis to determine why the deficient practices under F880 occurred. RCA and RCA Analysis Worksheets were completed. Measures or systemic changes to ensure that the deficiency will not recur: A Quality Assurance Performance Improvement plan was initiated. Administrator and/or designee to monitor	

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F 880	Continued From page 10 Review of the EMR for R#14 revealed an admission date of [redacted]. The EMR, under the diagnoses tab, revealed R#14 diagnoses include [redacted] Under the orders tab in the EMR, R#14 was ordered to have [redacted] four times a day. The physician's order was dated [redacted] Review of the EMR for R#20 under the "Census" tab revealed an admission date of [redacted] Under the "Diagnoses" tab, R#20 was diagnosed with [redacted]. Review of the "Physician's Orders" under the orders tab revealed an order for [redacted] Review of the EMR "Census" tab for R#297 revealed an admission date of [redacted]. Under the "Diagnoses" tab, R#297 was diagnosed with [redacted]. Review of the "Physician's Orders" under the "Orders" tab revealed an order for [redacted] four times a day. Interview on 09/25/24 at 9:30 AM, the [redacted] stated that the [redacted] wipes are in the medication cart to be used to disinfect the [redacted] after and between resident uses. Interview with the [redacted] on 09/27/24 at 2:30 PM, confirmed that [redacted] were to be disinfected after each patient use with an EPA -registered disinfectant. 2. Review of the facility's policy titled, "PPE Use" revealed that the facility promotes appropriate use of PPE to prevent the transmission of pathogens to residents, visitors, and staff. The policy also included that PPE will be disposed of	F 880	compliance through an audit that will be completed by DON or designee daily x2 weeks and then weekly x2 months by auditing the competency of nurses by observing disinfection technique of the glucometers during use and will conduct audits of 8 random visitors and staff for correct use of Personal Protective Equipment. All findings will be reported to the QAPI committee for review. Results of audit process will be reviewed at the Quarterly QAPI Meeting x2 quarters to ensure compliance and reassessed for further action. Date of Completion: 11/7/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	**336 PROSPECT AVE HACKENSACK, NJ 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
F 880	Continued From page 11 in an appropriate waste receptacle. Observation on 09/23/24 at 1:20 PM, revealed two rooms at the end of hallway [NJ Exec O], with two rooms labeled as being on NJ Ex Order 26.4(b)(1), across from other resident rooms. PPE equipment and signage was posted on each door with doors closed shut. Both residents were in their rooms throughout the survey process in [NJ Exec Order 26.4b1] On that same date and time, the surveyor observed a visitor coming out of R #198's room with PPE on and walked across the hall from the room where two large black trash receptors were located out of the room in the hallway to dispose of the used PPE. The two large black trash receptacles were labeled as "NJ Exec Order 26.4b1" with lids that currently were full. Further observation revealed there was no garbage can inside R #198's room at the door to dispose of used PPE. Interview on 09/23/24 at 1:20 PM, with R#198's Family Member (FM) #1 revealed that there was no trash receptor in the room other than a small one in the bathroom, so when he leaves the room, he uses the two large garbage cans across the hall to dispose of the contaminated PPE. Additional observation of R #197's room that was also on NJ Ex Order 26.4(b)(1) and required the use of full PPE, revealed having a large trash receptacle located inside of the room near the door to dispose of used PPE. Observation on 09/24/24 at 10:37 AM, revealed R#198's room still on NJ Ex Order 26.4(b)(1) for NJ Exec Order 26.4b1. Housekeeping (HSK)#1 was	F 880		

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F 880	Continued From page 12 cleaning the room with door wide open for at least 20 minutes. The resident was in the room in his/her bed. A large trash can was observed inside the room near the door. Interview with the [redacted], who used to be the [redacted] revealed that the expectations was to dispose of [redacted] inside the rooms and not in the hallway. The [redacted] further stated that housekeeping places the garbage cans and she was not sure why they were in the hallway. Interview with the [redacted] on 09/24/24 at 3:04 PM, revealed training was provided to the housekeeping staff on how to clean infectious/isolation rooms such as [redacted] rooms. Observation on 09/24/23 at 3:45 PM, revealed that the large black trash receptacles that were previously observed at the end of hallway 300 that were being used for [redacted] used PPE were removed. NJAC 8:39-19.4	F 880		

New Jersey Department of Health

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	056300	A. BUILDING: _____ B. WING _____	C 09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LL	336 PROSPECT AVE HACKENSACK, NJ 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) COMPLETE DATE
S 000	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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. Residents affected: All Residents. The following corrective action will be taken for those residents found to be affected: DON/Designee will review staffing needs with staffing coordinator regularly and check that staff par levels meet the required ratios. DON/Designee will continue to advertise staffing needs through recruitment agencies. No negative outcomes were observed. 2. All residents have the potential to be affected. 3. The following measures and systemic changes will be put in place to ensure the deficient practice will not recur: DON/Designee will review staffing needs	11/7/24

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

Electronically Signed | 10/17/24

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 3 weeks of Complaint staffing from 03/05/2023 to 03/24/2023, the facility was deficient in CNA staffing for residents on 15 of 21 day shifts and deficient in CNAs to total staff on 14 of 21 evening shifts as follows: -03/05/23 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -03/05/23 had 7 CNAs to 20 total staff on the evening shift, required at least 10 CNAs. -03/09/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -03/10/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -03/11/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs. -03/12/23 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs. -03/12/23 had 7 CNAs to 20 total staff on the evening shift, required at least 10 CNAs. -03/13/23 had 6 CNAs for 64 residents on the day	S 560	with staffing coordinator daily on an ongoing basis for progress and to assure mandatory staffing is maintained. HR Designee will continue to maintain a recruitment & hiring log, to track all Nurse and C.N.A. applicants and outcomes. Facility to continue to post open Nurse and C.N.A. positions on job sites and job fairs. Current Nurse and C.N.A. rates are at market rate. 5. The following programs will be put into place to monitor the continued effectiveness of the systemic changes: HR Designee will discuss staffing recruitment and retention plan monthly. Recommendations will be reviewed submitted quarterly to The Quality Assurance Performance Improvement (QAPI) Committee, chaired by the Administrator to review the audit to ensure compliance x12 months.	

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S 560	Continued From page 2	S 560		

shift, required at least 8 CNAs.
-03/13/23 had 7 CNAs to 24 total staff on the evening shift, required at least 12 CNAs.
-03/14/23 had 6 CNAs to 26 total staff on the evening shift, required at least 13 CNAs.
-03/15/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-03/15/23 had 6 CNAs to 27 total staff on the evening shift, required at least 13 CNAs.
-03/16/23 had 8 CNAs to 29 total staff on the evening shift, required at least 14 CNAs.
-03/17/23 had 7 CNAs for 66 residents on the day shift, required at least 8 CNAs.
-03/17/23 had 7 CNAs to 26 total staff on the evening shift, required at least 13 CNAs.
-03/18/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-03/18/23 had 6 CNAs to 16 total staff on the evening shift, required at least 8 CNAs.
-03/19/23 had 6 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-03/20/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-03/20/23 had 8 CNAs to 21 total staff on the evening shift, required at least 10 CNAs.
-03/21/23 had 7 CNAs for 64 residents on the day shift, required at least 8 CNAs.
-03/21/23 had 7 CNAs to 20 total staff on the evening shift, required at least 10 CNAs.
-03/22/23 had 6 CNAs for 63 residents on the day shift, required at least 8 CNAs.
-03/22/23 had 9 CNAs to 23 total staff on the evening shift, required at least 11 CNAs.
-03/23/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs.
-03/23/23 had 7 CNAs to 20 total staff on the evening shift, required at least 10 CNAs.
-03/24/23 had 8 CNAs to 25 total staff on the evening shift, required at least 12 CNAs.
-03/25/23 had 6 CNAs for 62 residents on the day

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S 560	Continued From page 3 shift, required at least 8 CNAs. -03/25/23 had 8 CNAs to 19 total staff on the evening shift, required at least 9 CNAs. 2. For the 2 weeks of Complaint staffing from 08/20/2023 to 09/02/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -08/24/23 had 6 CNAs for 62 residents on the day shift, required at least 8 CNAs. -08/26/23 had 7 CNAs for 63 residents on the day shift, required at least 8 CNAs. -08/28/23 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs. -08/29/23 had 7 CNAs for 72 residents on the day shift, required at least 9 CNAs. -08/31/23 had 8 CNAs for 72 residents on the day shift, required at least 9 CNAs. 3. For the 2 weeks of Complaint staffing from 11/19/2023 to 12/02/2023, the facility was deficient in CNA staffing for residents on 5 of 14 day shifts as follows: -11/19/23 had 9 CNAs for 78 residents on the day shift, required at least 10 CNAs. -11/20/23 had 8 CNAs for 78 residents on the day shift, required at least 10 CNAs. -11/24/23 had 8 CNAs for 78 residents on the day shift, required at least 10 CNAs. -11/25/23 had 8 CNAs for 78 residents on the day shift, required at least 10 CNAs. -11/26/23 had 8 CNAs for 78 residents on the day shift, required at least 10 CNAs. 4. For the 2 weeks of Complaint staffing from 01/14/2024 to 01/27/2024, the facility was deficient in CNA staffing for residents on 14 of 14	S 560		

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S 560	Continued From page 4 day shifts as follows: -01/14/24 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. -01/15/24 had 7 CNAs for 92 residents on the day shift, required at least 11 CNAs. -01/16/24 had 8 CNAs for 91 residents on the day shift, required at least 11 CNAs. 01/17/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -01/18/24 had 8 CNAs for 90 residents on the day shift, required at least 11 CNAs. -01/19/24 had 8 CNAs for 90 residents on the day shift, required at least 11 CNAs. -01/20/24 had 9 CNAs for 90 residents on the day shift, required at least 11 CNAs. -01/21/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -01/22/24 had 9 CNAs for 97 residents on the day shift, required at least 12 CNAs. -01/23/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -01/24/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -01/25/24 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -01/26/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. -01/27/24 had 7 CNAs for 104 residents on the day shift, required at least 13 CNAs. 5. For the 2 weeks of Complaint staffing from 03/10/2024 to 03/23/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -03/10/24 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -03/11/24 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs.	S 560		

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S 560	Continued From page 5 -03/12/24 had 8 CNAs for 100 residents on the day shift, required at least 12 CNAs. -03/13/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -03/14/24 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -03/15/24 had 9 CNAs for 96 residents on the day shift, required at least 12 CNAs. -03/16/24 had 8 CNAs for 96 residents on the day shift, required at least 12 CNAs. -03/17/24 had 10 CNAs for 96 residents on the day shift, required at least 12 CNAs. -03/18/24 had 7 CNAs for 98 residents on the day shift, required at least 12 CNAs. -03/19/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -03/20/24 had 8 CNAs for 95 residents on the day shift, required at least 12 CNAs. -03/21/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -03/22/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. -03/23/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. 6. For the 2 weeks of Complaint staffing from 06/02/2024 to 06/15/2024, the facility was deficient in CNA staffing for residents on 4 of 14 day shifts as follows: -06/02/24 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs. -06/04/24 had 9 CNAs for 94 residents on the day shift, required at least 12 CNAs. -06/07/24 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. -06/15/24 had 9 CNAs for 95 residents on the day shift, required at least 12 CNAs. 7. For the 2 weeks of Complaint staffing from	S 560		

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S 560	Continued From page 6 08/25/2024 to 09/07/2024, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -08/25/24 had 8 CNAs for 94 residents on the day shift, required at least 12 CNAs. -08/30/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -08/31/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs. -09/01/24 had 10 CNAs for 97 residents on the day shift, required at least 12 CNAs. -09/02/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/05/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/06/24 had 11 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/07/24 had 9 CNAs for 100 residents on the day shift, required at least 12 CNAs. 8. For the 2 weeks of staffing prior to survey from 09/08/2024 to 09/21/2024, the facility was deficient in CNA staffing for residents on 8 of 14 day shifts as follows: -09/08/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/09/24 had 10 CNAs for 100 residents on the day shift, required at least 12 CNAs. -09/14/24 had 8 CNAs for 103 residents on the day shift, required at least 13 CNAs. -09/15/24 had 6 CNAs for 102 residents on the day shift, required at least 13 CNAs. -09/16/24 had 9 CNAs for 98 residents on the day shift, required at least 12 CNAs. -09/17/24 had 11 CNAs for 98 residents on the day shift, required at least 12 CNAs. -09/20/24 had 11 CNAs for 97 residents on the day shift, required at least 12 CNAs.	S 560		

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S 560	Continued From page 7 -09/21/24 had 11 CNAs for 96 residents on the day shift, required at least 12 CNAs.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315460 Y1	A. Building B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/07/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/27/2024	☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315460 Y1	A. Building B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0695	Correction	ID Prefix F0732	Correction	ID Prefix F0880	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.35(g)(1)-(4)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed
LSC	11/07/2024	LSC	11/07/2024	LSC	11/07/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/27/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
056300 Y1	A. Building B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/07/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
056300 Y1	A. Building B. Wing Y2	11/19/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/07/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING **01** B. WING _____	**09/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	**336 PROSPECT AVE** **HACKENSACK, NJ 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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 09/25/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 09/25/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Complete Care at Prospect Heights is a seven-story building with a basement and sub-basement built in 1999. It is composed of Type I protected construction. The facility is divided into 12 - smoke zones. The generator does approximately 75 % of the building per Maintenance Supervisor. The current occupied beds are 96 of 132.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324		10/31/24

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

Electronically Signed | 10/20/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING **01** B. WING _____	**09/27/2024**

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

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K 324	Continued From page 1 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen griddle and deep fryer were separated correctly; and failed to ensure the exhaust hood grilles were not damaged in accordance with NFPA 96 Ventilation Control and Fire Protection of Commercial Cooking Operations (2011 Edition) Section 6.2.3.2 and 12.1.2.5.1. This deficient practice had the potential to affect all 96 residents who resided at the facility. Findings include: An observation on 09/25/24 at 1:19 PM revealed the griddle and deep fryer were butted up against each other with a vertical shield which measured 3 ¾ " high. The measurement was taken with the Maintenance Supervisor observing.	K 324	Residents affected by deficient practice: * The deficient practice has the potential to affect all 96 residents who reside at the facility. Identify those individuals who could be affected by the deficient practice: * No residents were directly affected by a 3 inch vertical shield deficient practice vs. a 8 inch vertical shield, however there was a potential to affect all 96 residents who reside at the facility. * No residents were directly affected by the Kitchen Stainless Steel Hood Filter that was damaged, however there was a potential to affect all 96 residents who reside at the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING **01** B. WING _____	**09/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	**336 PROSPECT AVE** **HACKENSACK, NJ 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
K 324	Continued From page 2 An observation on 09/25/24 at 1:20 PM revealed the exhaust grill had damage that caused holes in the ventilation system. During an interview at the time of observations, the U.S. FOIA (b) (6) confirmed the lack of the required separation between the griddle and the deep fryer. The NJ Ex Order 26.4b1 also verified the holes in the exhaust grilles. NJAC 8:39-31.2(e) NFPA 96	K 324	What corrective action will be accomplished for those residents affected by the deficient practice: * The vertical shield measuring 3 inches was replaced with a vertical shield that measured 8 inches high and remediation completed. * The Kitchen Stainless Steel Hood Filter was replaced and remediation completed. Measures or systemic changes to ensure that the deficiency will not recur: * The Environmental Services Director/Designee will monitor bi-annually to ensure compliance of cooking equipment. Any issues will be addressed immediately and audits will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Results of audit process will be reviewed at the Quarterly QAPI Meeting x1 quarter to ensure compliance and reassessed for further action. Date of Completion: 10/31/2024	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available.	K 345		11/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING 01 B. WING _____	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 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
K 345	Continued From page 3 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure smoke detection sensitivity testing of the smoke detectors were completed every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 96 residents who resided at the facility. Findings include: A review of the facility's "Inspection and Testing Reports," dated 09/25/24, provided by the Maintenance Supervisor, revealed the report had no reference to a smoke detection sensitivity test. Observations on 09/25/24 from 11:30 AM to 1:45 PM revealed the smoke detectors were in the corridors and other concealed areas throughout the building. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed the smoke sensitivity testing had not been completed on the smoke detectors. NJAC 8:39-31.2(e) NFPA 72	K 345	Residents affected by deficient practice: * The deficient practice has the potential to affect all 96 residents who reside at the facility. Identify those individuals who could be affected by the deficient practice: * No residents were directly affected by the deficient practice, however there was a potential to affect all 96 residents who reside at the facility. What corrective action will be accomplished for those residents affected by the deficient practice: * The Smoke Detectors Smoke Sensitivity Testing scheduled to be included as part of maintenance of fire alarm system and remediation completed. Measures or systemic changes to ensure that the deficiency will not recur: * The Environmental Services Director/Designee will monitor every two (2) years to ensure compliance with NFPA 72 National Fire Alarm Coding and Signaling Code Section 14.4.5.3.2. Any issues will be addressed immediately and audits will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Results of audit process will be reviewed at the Quarterly QAPI Meeting x1 quarter to ensure compliance and reassessed for further action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING **01** B. WING _____	**09/27/2024**

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

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K 345	Continued From page 4	K 345		
			Date of Completion: 11/1/2024	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure the smoke barrier was sealed with fire rated material in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 8.5.2.2. This deficient practice had the potential to affect 96 residents who resided on the sixth floor of the facility. Findings include: Observations on 09/25/24 at 1:47 PM of the West Wing on the sixth floor near the nurses' station revealed two metal clad wires, three metal clad wires, five cat-5 wiring, and one low voltage wire penetrated the smoke barrier above the smoke doors and were not sealed with fire rated material.	K 372	Residents affected by deficient practice: * The deficient practice has the potential to affect all 96 residents who reside at the facility. Identify those individuals who could be affected by the deficient practice: * No residents were directly affected by the deficient practice, however there was a potential to affect all 96 residents who reside at the facility. What corrective action will be accomplished for those residents affected by the deficient practice: * The 6th Floor East and West Wing penetrations of the smoke barrier above	10/31/24

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	315460	A. BUILDING **01** B. WING _____	**09/27/2024**

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

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K 372	Continued From page 5 Observations on 09/25/24 at 2:05 PM of the East Wing on the sixth floor near the nurses' station revealed one non-metallic sheath cable, one low voltage wire, and nine metal clad wires penetrated the smoke barrier above the smoke doors were not sealed with fire rated material. During an interview at the time of observations, the U.S. FOIA (b) (6) confirmed the wires that penetrated the smoke barrier was not sealed with fire rated material. NJAC 8:39-31.2(e)	K 372	the smoke doors were sealed with fire rated material in accordance with NFPA 101 Life Safety Code Section 8.5.2.2 and remediation completed. NJ Ex Order 26.4(b)(1) 5000 is the sealant used and is an advanced flexible intumescent acrylic latex fire stop sealant “intumesces”. Measures or systemic changes to ensure that the deficiency will not recur: * The Environmental Services Director/Designee will monitor bi-annually to ensure compliance of cooking equipment. Any issues will be addressed immediately and audits will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Results of audit process will be reviewed at the Quarterly QAPI Meeting x1 quarter to ensure compliance and reassessed for further action. Date of Completion: 10/31/2024	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K 761		10/2/24

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K 761	Continued From page 6 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure fire doors were inspected by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 96 residents who resided at the facility. Findings include: A review of the facility's untitled fire safety binder provided by the facility revealed the facility's fire doors were not inspected annually in accordance with NFPA 101. Observations on 09/25/24 from 11:30 AM to 1:45 PM of the facility's fire doors revealed the doors' fire rating tags were painted over, and the fire rating was not legible. During an interview at the time of each observation, the U.S. FOIA (b) (6) confirmed the fire doors' tags were painted and the fire doors were not being inspected annually. NJAC 8:39-31.2(e) NFPA 80	K 761	Residents affected by deficient practice: * The deficient practice has the potential to affect all 96 residents who reside at the facility. Identify those individuals who could be affected by the deficient practice: * No residents were directly affected by the deficient practice, however there was a potential to affect all 96 residents who reside at the facility. What corrective action will be accomplished for those residents affected by the deficient practice: * The facility's fire doors were inspected in accordance with NFPA 101 and fire doors that revealed fire rating tags painted over were remediated. Measures or systemic changes to ensure that the deficiency will not recur: * The Environmental Services Director/Designee will review all fire doors as part of weekly safety rounds. Any issues will be addressed immediately and audits will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Results of audit process will be reviewed at the Quarterly QAPI Meeting x1 quarter to ensure compliance and reassessed for further action.	

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	315460	A. BUILDING **01** B. WING _____	**09/27/2024**

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K 761	Continued From page 7	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918	Date of Completion: 10/2/2024	10/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING 01 B. WING _____	09/27/2024

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COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 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
K 918	Continued From page 8 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a load bank test was completed on the emergency generator once every 36 months in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.4.9. This deficient practice had the potential to affect all 96 residents who resided at the facility. Findings include: A review of the facility's untitled generator reports dated for the years 2023 and 2024, provided by the facility revealed a three-year load bank test had not been completed for the emergency generator. Continued review of the reports revealed it had been over 36 months since the emergency generator had a load bank test completed. During an interview on 09/25/24 at 12:40 PM, the U.S. FOIA (b) (6) confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	Residents affected by deficient practice: * The deficient practice has the potential to affect all 96 residents who reside at the facility. Identify those individuals who could be affected by the deficient practice: * No residents were directly affected by the deficient practice, however there was a potential to affect all 96 residents who reside at the facility. What corrective action will be accomplished for those residents affected by the deficient practice: * The 3-year Generator Load Bank Test scheduled to be included as part of maintenance of generator and remediation completed. Measures or systemic changes to ensure that the deficiency will not recur: * The Environmental Services Director/Designee will monitor weekly, monthly and tri-annual the maintenance logs of the generator to ensure compliance with NFPA 110 Standard for Emergency and Standby Power Systems Section 8.4.9. Any issues will be addressed immediately and audits will be reviewed at the Quarterly QAPI Meeting to ensure compliance and reassessed for further action. Results of audit process will be reviewed at the Quarterly QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. BUILDING **01** B. WING _____	**09/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	**336 PROSPECT AVE** **HACKENSACK, NJ 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
K 918	Continued From page 9	K 918	Meeting x1 quarter to ensure compliance and reassessed for further action. Date of Completion: 10/31/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315460 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/21/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT PROSPECT HEIGHTS LLC	336 PROSPECT AVE HACKENSACK, NJ 07601

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0324	10/31/2024	LSC K0345	11/01/2024	LSC K0372	10/31/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0761	10/02/2024	LSC K0918	10/31/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO