STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315295	A. BUILDING _____ B. WING _____	C 02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	**50 POLIFLY ROAD 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 000	INITIAL COMMENTS C#:NJ00170087 Census: 157 Sample: 4 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		

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

Electronically Signed | 03/08/2024

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
	060231	A. BUILDING: _____ B. WING _____	C 02/22/2024

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COMPLETE CARE AT REGENT LLC	50 POLIFLY ROAD HACKENSACK, NJ 07601

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S 000	Initial Comments C#00170087 CENSUS: 157 SAMPLE SIZE: 4 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: Complaint # NJ 00170087 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 27 of 28 day shifts. The deficient practice was evidenced by the following:	S 560	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 full-time staff were scheduled to meet the minimum staff-to-resident ratios. The staffing manager/Human Resources	3/15/24

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

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S 560	Continued From page 1 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 as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide 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. The surveyor requested staffing for the weeks of 12/17/23 to 12/30/23 and 02/4/2024 to 02/17/2024. The facility was deficient in CNA staffing for resident on 27 of 28 day shift: -12/17/23 had 12 CNAs for 156 residents on the day shift, required at least 19 CNAs. -12/18/23 had 17 CNAs for 156 residents on the day shift, required at least 19 CNAs. -12/20/23 had 15 CNAs for 156 residents on the day shift, required at least 19 CNAs. -12/21/23 had 15 CNAs for 156 residents on the day shift, required at least 19 CNAs. -12/22/23 had 18 CNAs for 157 residents on the day shift, required at least 20 CNAs. -12/23/23 had 17 CNAs for 157 residents on the	S 560	verified licenses and certifications for current staff members. The Director of Nursing (DON) or their designee provided in-service training to the Staffing Coordinator regarding appropriate staffing levels. The facility utilized various recruitment methods, including online platforms, traditional recruitment firms, job fairs, and contracts with nursing staffing agencies, to fill open positions. The Scheduling Manager or their designee will conduct weekly audits for four weeks and monthly audits for two months to ensure staffing levels are within the mandated ratios. Any identified concerns will be promptly addressed, and corrective actions will be implemented immediately. The results of these audits will be reviewed monthly during Quality Assurance and Performance Improvement (QAPI) meetings.	

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S 560	Continued From page 2 day shift, required at least 20 CNAs. -12/24/23 had 16 CNAs for 157 residents on the day shift, required at least 20 CNAs. -12/25/23 had 14 CNAs for 157 residents on the day shift, required at least 20 CNAs. -12/26/23 had 16 CNAs for 153 residents on the day shift, required at least 19 CNAs. -12/27/23 had 18 CNAs for 153 residents on the day shift, required at least 19 CNAs. -12/28/23 had 17 CNAs for 152 residents on the day shift, required at least 19 CNAs. -12/29/23 had 13 CNAs for 151 residents on the day shift, required at least 19 CNAs. -12/30/23 had 14 CNAs for 151 residents on the day shift, required at least 19 CNAs. -02/04/24 had 16 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/05/24 had 16 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/06/24 had 16 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/07/24 had 18 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/08/24 had 13 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/09/24 had 18 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/10/24 had 17 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/11/24 had 18 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/12/24 had 17 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/13/24 had 18 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/14/24 had 17 CNAs for 158 residents on the day shift, required at least 20 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 3 -02/15/24 had 15 CNAs for 158 residents on the day shift, required at least 20 CNAs. -02/16/24 had 16 CNAs for 160 residents on the day shift, required at least 20 CNAs. -02/17/24 had 16 CNAs for 159 residents on the day shift, required at least 20 CNAs.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060231 Y1	A. Building B. Wing Y2	3/18/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	50 POLIFLY ROAD 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	03/15/2024	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	
2/22/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO