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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	50 POLIFLY ROAD HACKENSACK, NJ 07601

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F 000	INITIAL COMMENTS Complaint #: NJ00156501, NJ00163874, NJ00158442, NJ00165376, NJ00165530, NJ00167200, NJ00164458, NJ00165661 Survey Date: 10/2/2023 Census: 147 Sample: 43 + 3 closed records 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.	F 000		
F 640 SS=E	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 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	F 640		11/3/23

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

Electronically Signed | 10/26/2023

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 640	Continued From page 1 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 format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete and/or timely transmit the Minimum Data Set (MDS) for 5 of 46 residents reviewed, Residents #13, #37, #51, #131, #113. The deficient practice was evidenced by the following: On 9/26/23 at 12:30 PM, the surveyor reviewed	F 640	Upon notification MDSs reviewed and any late MDSs were submitted. All residents in the facility have the potential to be affected by this deficient practice. DON educated MDS coordinator on timely completion and transmission of MDS□s.	

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F 640	Continued From page 2 the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS up to 14 days of the assessment being completed. The following residents were identified as not to having their MDS transmitted timely: 1. Resident #13 was observed to have a Discharge Return Not Anticipated MDS with Assessment Reference Date (ARD) of [NJ ex order 26.4b] and was due to be transmitted no later than [NJ ex order 26.4b]. The MDS was not transmitted until [NJ ex order 26.4b]. Further review of Resident #13's MDS assessments revealed that the resident had an Entry MDS (E/MDS) with [NJ ex orde] of [NJ ex order 26.4] and was due to be transmitted no later than [NJ ex order 26.4b]. The E/MDS was not transmitted until [NJ ex order 26.4b]. 2. Resident #37 was observed to have a Discharge Return Anticipated MDS with ARD of [NJ ex order 26.] and was due to be completed no later than [NJ ex order 26.4b]. The MDS was not completed until [NJ ex order 26.4b]. 3. Resident #51 was observed to have an Admission/Medicare 5-Day MDS with ARD of [NJ ex order 26.4b] and was due to be completed no later than [NJ ex order 26.4b]. The MDS was not completed until [NJ ex order 26.]. 4. Resident #131 and Resident #113 revealed under Resident Assessment Task indicating [NJ ex order 26.4b1]	F 640	The DON/designee will conduct an audit weekly x 4 weeks, then monthly x 2 months to ensure timely submission of MDS□s. The result of the audits will be presented at the monthly QAPI meetings.	

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F 640	Continued From page 3 According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2019) revealed on page 2-16 "Admission (Comprehensive) must be completed no later than 14th calendar day of the resident's admission (admission date +13 calendar days) ...On page 2-18, "Discharge Assessment-return anticipated must be completed no later than Discharge Date + 14 calendar days" and on the same page indicated under "Entry tracking record must be transmitted no later than entry date +14 calendar days ... On page 2-17, "Discharge Assessment-return not anticipated must be transmitted no later than MDS Completion Date + 14 calendar days ..." On 9/27/23 at 10:33 AM, the survey team interviewed the RN (Registered Nurse)/MDS Coordinator who stated the facility had switched to a different electronic medical record (EMR) as of May 2023. The RN/MDS Coordinator further stated that the facility was still given the access to the old EMR to review and transfer the old medical records to the new EMR. The RN/MDS coordinator stated that she had a clerk that was in charge to keep track of the MDS scheduling. On 9/28/23 1:12 PM, the facility's Regional Registered Nurse who was performing as the acting Director of Nursing (DON) at the facility, provided a copy of a form titled, "MDS 3.0 NH Final Validation Report" which confirmed that Resident #13, Resident #37, and Resident #51 were completed and/or transmitted late in accordance with the regulations. The facility was not able to provide further information or documentation for Resident #131 and Resident	F 640		

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	315295	A. BUILDING _____ B. WING _____	C 10/02/2023

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F 640	Continued From page 4 #113. On 9/27/23 at 1:30P PM, the surveyors informed the facility's Administrator and acting DON of the above concerns. The acting DON acknowledged that the above MDS assessments were completed and/or transmitted late in accordance with the regulation. NJAC 8:39 - 11.1	F 640		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to accurately code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, in accordance with federal guidelines for 7 of 29 residents, Resident #3, #135, #8, #15, #126, #204, and #98 reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 9/20/2023 at 11:30 AM, the surveyor observed Resident #3 in their room watching television. The surveyor also observed that the resident was only able to communicate in Russian. The surveyor reviewed Resident #3's electronic medical record (EMR).	F 641	Upon notification MDSs reviewed and assessments modified for R3, R135, R8, R15, R126, R204 and R98 to ensure accuracy. All residents in the facility have the potential to be affected by this deficient practice. DON/designee educated MDS coordinator on importance of accuracy of coding on the MDS. The DON/designee will conduct an audit of 10 resident MDS□s weekly x 4 weeks then monthly x 2 months to ensure sections A1100: LANGUAGE, A2100: (NOW A2105) DISCHARGE STATUS, O0100E2: TRACHEOSTOMY, P0200E: WANDER GUARD, I2300: UTI, N0410	11/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 5 Review of Resident #3's Face Sheet (FS) (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility on [NJ ex order 26.4b1] with diagnosis that included but were not limited to [NJ ex order 26.4b1] [redacted]. Review of the "A section" of the [NJ ex order 26.4b1] Quarterly MDS for Resident #3 revealed that section "A1100 Language" (used to determine if the resident needs or wants an interpreter to communicate with a doctor or health care staff) documented "0. [NJ ex]", but [NJ ex order 26.4b1] [redacted]. On 9/25/2023 at 12:22 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who was the assigned nurse for Resident #3 during the 7AM to 3PM shift. LPN #1 confirmed that the resident [NJ ex order 26.4b1] [redacted] LPN #1 further explained that the facility staff uses a communication board with Resident #3 as well as calling the resident's family to translate. On 9/27/2023 at 10:30 AM, the survey team interviewed the MDS coordinator. The MDS coordinator explained, "The part time MDS person incorrectly coded the resident's language." The surveyor reviewed the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual updated October 2019. The manual indicated for, Coding Instructions for A1100A, "Code 1, yes: if the resident (or family or medical record if	F 641	(NOW N0415): ANTICOAGULANT of the MDS□s are complete and transmitted accurately. The results of the audits will be presented at the monthly QAPI meetings.	

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F 641	Continued From page 6	F 641		

resident unable to communicate) indicates that he or she needs or wants an interpreter to communicate with a doctor or health care staff. Proceed to 1100B and enter the resident's preferred language."

On 9/27/2023 at 1:37 PM, the surveyor team discussed the relative concerns with the Licensed Nursing Home Administrator (LNHA) and Acting Director of Nursing (DON). The DON acknowledged that Resident #3's MDS should have been coded to reflect the resident's primary language as Russian. No further information was provided.

2. On 9/26/23 at 1:03 PM, the surveyor reviewed the closed medical record for Resident #204. The closed record revealed that Resident #204 was admitted to the facility on [NJ ex order 26.4b].

The surveyor reviewed Resident #204's EMR.

A review of Resident #204's FS documented the resident's diagnosis which included but was not limited to NJ ex order 26.4b1 [redacted]

The surveyor reviewed Resident #204's Nursing Interdisciplinary Progress Notes dated [NJ ex order 26.4b], which documented that Resident #204 was NJ ex order 26.4b1 [redacted]

The surveyor reviewed the Physician Discharge Summary for Resident #204 which documented Resident #204 was NJ ex order 26.4b1 [redacted] on [NJ ex order 26.4b1]

The surveyor reviewed Resident #204's Notice of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 7	F 641		

Emergency Transfer, which documented that the resident was transferred to the hospital on [NJ ex order 26.4b]

The surveyor reviewed the New Jersey Universal Transfer Form for Resident #204, which documented that the resident was [NJ ex order 26.4b1] on [NJ ex order 26.4] at 5:00 PM.

A review of Resident #204's MDS, dated [NJ ex order 26.4], revealed under Section A2100 "[NJ ex order 26.4b1]" coded "[NJ ex]" indicating that the resident was [NJ ex order 26.4b1].

On 9/27/23 at 10:34 AM, the survey team met with the MDS Coordinator to review Resident #204's [NJ ex order 26.4b1] dated [NJ ex order 26.4], coded under "[NJ ex order 26.4b1]" indicating resident [NJ ex order 26.4b1].

After review of the discharge documents mentioned above with the MDS Coordinator, documenting that Resident #204 was [NJ ex order 26.4b1] on [NJ ex order 26.4], the MDS Coordinator indicated that the discharge status was coded incorrectly. The MDS Coordinator indicated that the discharge coding for Resident #204 should have been to "[NJ ex order 26.4b1]."

On 9/27/23 at 1:35 PM, the survey team met with the LNHA and DON to discuss the concern above. No further information was provided.

A review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual updated October 2019, Chapter 3 MDS Items [A] section A2100: OBRA Discharge Status under Coding Instructions stated, "Code 01, community (private

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F 641	Continued From page 8	F 641		

home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home".

3. On 9/27/23 at 10:44 AM, Resident #98 was observed NJ ex order 26.4b1 Resident #98's NJ ex order 26.4b1 . The surveyor noted that the resident was NJ ex order 26.4b1 (min). Resident #98 also had a NJ ex order 26.4b1

The surveyor reviewed the resident's EMR.

A review of Resident #98's FS documented the resident's diagnosis which included but was not limited to NJ ex order 26.4b1

A review of the Resident #98's Annual MDS dated NJ ex order 26.4b, revealed under section "O" category NJ ex order 26.4b1

The surveyor reviewed Resident #98 Nursing Comprehensive Assessment (facility admission assessment) dated NJ ex order 26.4b under section F, "NJ ex order 26.4b1 " documented that Resident #98 was NJ ex order 26.4b1 .

A review of Resident #98's Physician's order (PO) revealed an order for NJ ex order 26.4b1 "NJ ex order 26.4b1 " initiated on NJ ex order 26.4b .

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 10/02/2023

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F 641	Continued From page 9	F 641		

A review of Resident #98's electronic Treatment Administration Record (eTAR) for the month of [NJ ex order 26.4b1], documenting nursing signatures demonstrating [NJ ex order 26.4b1] every shift from [NJ ex order 26.4b1].

On 9/27/23 at 1:14 PM, the surveyor reviewed Resident #98's [NJ ex order 26.4b] Annual MDS with the MDS Coordinator. The [NJ ex order 26.4b] Annual MDS did not reveal [NJ ex order 26.4b1] while the resident was in the facility, it was not coded in section [NJ ex order 26.4b1]. The MDS Coordinator acknowledged the coding error, verifying that Resident #98 should have been coded as receiving [NJ ex order 26.4b1] if the [NJ ex order 26.4b] Annual MDS.

On 9/27/23 at 1:35 PM, the surveyor met with the LNHA and DON to discuss the above concerns. No further information was provided.

4. On 9/20/23 at 11:55 AM, the surveyor met with Resident #126 at their bedside. The resident was observed with a [NJ ex order 26.4b1]

On 9/26/23 at 11:08 AM, another surveyor observed Resident #126 [NJ ex order 26.4b1] attending activities in the dining room near the nursing station. [NJ ex order 26.4b1] on Resident #126.

The surveyor reviewed the resident's EMR.

A review of Resident #126's FS documented the resident's diagnosis which included but was not limited [NJ ex order 26.4b1]

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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 10	F 641		

A review of Resident #126's Quarterly MDS dated [redacted], revealed under section P0200E wander/elopement alarm coded "[redacted]" indicating [redacted].

A review of Resident #126's PO, revealed an order initiated on [redacted] for [redacted] This PO was noted as discontinued on [redacted].

The surveyor reviewed Resident #126's [redacted] eTAR, which revealed a documented PO for a [redacted]

On 9/27/23 at 10:34 AM, the survey team met with the MDS Coordinator to review Resident #126's Quarterly MDS dated [redacted] section P0200E wander/elopement alarm coded as "[redacted]" indicating "[redacted]."

On 9/27/23 at 1:09 PM, the surveyor interviewed the MDS Coordinator who explained that during her review of the [redacted] Quarterly MDS she found that it was coded incorrectly. The MDS Coordinator revealed that the P0200E should have been coded as a "[redacted]" indicating "[redacted]."

On 9/27/23 at 1:35 PM, the survey team met with the LNHA and DON to discuss the above concern. No further information was provided.

5. On 9/21/23 at 10:51 AM, the surveyor observed Resident #135 in the day room seated in a chair. The surveyor interviewed the resident and observed that the resident was only able to

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641	Continued From page 11	F 641		

NJ ex order 26.4b1 .

The surveyor reviewed the resident's EMR.

The surveyor reviewed Resident #135's FS. The resident was admitted to the facility with diagnosis that included but not limited to NJ ex order 26.4b1

The surveyor reviewed Resident #135's quarterly MDS assessment dated NJ ex order 26.4b1 under Section A1100, documented as "NJ Exec. Order 26.4b1 but the resident NJ ex order 26.4b1 .

According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated NJ ex order 26.4b1) on page A-19 ... "Enter the preferred language the resident primarily speaks or understands after interviewing the resident ..."

6. On 9/21/23 at 10:30 AM, the surveyor observed Resident #15 in bed, awake and watching television inside their room.

The surveyor reviewed Resident #15's EMR.

The Resident's FS documented addition to the facility with diagnosis that included but was not limited to NJ ex order 26.4b1

Further review of the records revealed that the nurse practitioner (NP) documented on the NJ ex order 26 Progress Notes for Resident #15 to start on an NJ ex order 26.4b1 .

A review of Resident #15's electronic Medication Administration Record (eMAR) revealed that the

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 10/02/2023

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 641		F 641		

Continued From page 12

resident was given [redacted] to [redacted] The NP ordered, "[redacted]"

The surveyor reviewed the [redacted] quarterly MDS Assessment under Section I - Active Diagnosis, "[redacted]." [redacted] (Last 30 days) was coded as "No".

According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated [redacted]) on page I-20 ... [redacted] ..." 2. A physician documented [redacted] (or by a nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) in the last 30 days."

On 9/27/23 at 10:33 AM, the surveyor discussed the above discrepancy with the MDS Coordinator. The MDS Coordinator revealed that the [redacted] section of the [redacted] Quarterly MDS was coded incorrectly for Resident #15. The MDS Coordinator revealed that the "[redacted]" section should have been coded as "Yes."

7. On 9/21/23 at 10:31 AM, the surveyor observed Resident #8 in the day room [redacted]

The surveyor reviewed Resident #8's EMR.

Review of the resident's facility admission FS documented diagnosis that included but were not limited to [redacted].

The surveyor reviewed the most recent Quarterly

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 10/02/2023

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 641	Continued From page 13 MDS assessment dated 8/25/23 under Section "N0410," "E. Medications received: Days: NJ ex order 26.4b1." This section reflected that Resident #8 received NJ ex order 26.4b1 A review of the NJ ex order 26.4b1 eMAR revealed a physician's order dated NJ ex order 26.4b for NJ ex order 26.4b1 According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated NJ ex order 26.4b1) on page N-7 ... "NJ ex order 26.4b, NJ ex order 26.4b1 Record the number of days an NJ ex order 26.4b1 by the resident at any time during the 7-day look back period ... NJ ex order 26.4b1 ...." On 9/27/23 at 10:33 AM, the survey team interviewed the facility's MDS Coordinator, who was responsible in completing the MDS assessments. The MDS Coordinator indicated that the above MDS assessments were coded incorrectly to reflect the most current status of the residents. The MDS Coordinator agreed that Aspirin is not considered an anticoagulant as per the RAI manual. On 9/27/23 at 1:30 PM, the above concerns were discussed within the facility's LNHA and the DON, who did not provide any further information. NJAC 8:39-11.1, 11.2(e)(1)	F 641		
F 658 SS=D	Services Provided Meet Professional Standards	F 658		11/3/23

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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 14 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, interviews, medical records, and facility policies, it was determined that the facility failed to follow acceptable standards of clinical practice with regards to 1. label and date an NJ ex order 26.4b1 deficient practice was observed for Resident #135, 1 of 3 facility residents reviewed for NJ ex order 26.4b1 and 2. accurately following a physician's order (PO) for parameters. This deficient practice was observed for Resident #135, 1 of 5 residents reviewed for following a PO for parameter accuracy. The 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." 1. On 9/20/2023 at 11:41 AM, the surveyor	F 658	Upon notification an audit of all residents with enteral feedings was immediately done to ensure all enteral feedings and water flush bags were labeled and dated appropriately and all residents with parameters on medication were reviewed to ensure parameters were being followed. All residents with enteral feedings and medications with parameters have the potential to be affected by this deficient practice. DON and Facility Educator educated all nurses regarding properly labeling enteral feedings and flush bags as well as adhering to parameters when administering blood pressure medications such as Midodrine. DON/designee will audit all residents on enteral feedings weekly to ensure proper labeling of enteral feedings and flush bags as well as all residents with blood pressure parameters to ensure parameters are being followed for 4 weeks and monthly thereafter for 2 months. The results of the audits will be presented at the monthly QAPI meetings.	

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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	50 POLIFLY ROAD HACKENSACK, NJ 07601

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F 658		F 658		

Continued From page 15

observed Resident #18 NJ ex order 26.4b1 NJ Exec. Order 26:4.b.1 NJ ex order 26.4b1 The surveyor also observed that there was a NJ ex order 26.4b1 . The surveyor noted that the NJ ex order 26.4b1 was not labeled with resident's name, room number, NJ ex order 26.4b1

On 9/21/23 at 10:11 AM, the surveyor had a second observation of Resident #18 with NJ ex order . was not labeled with the necessary required information.

At that time the surveyor interviewed the Licensed Practicing Nurse (LPN#1) in the resident's room. LPN#1 confirmed that the observed NJ ex order 26.4b1 with the required information. LPN #1 stated the NJ ex order 26.4b1 with the resident's name, room number, NJ ex order 26.4b1 , total volume, date, and NJ ex order 26.4b1 . LPN #1 further stated that the NJ ex order 26.4b1 is scheduled to be started during the 3-11 PM shift, explaining that the NJ Exec. Order 26:4.b.1 was started the previous day.

A review of Resident #18's Face Sheet (FS) (a one-page summary of important information about the patient) reflected that the resident was admitted to the facility on NJ ex order 26.4b1 with diagnosis that included but were not limited to NJ ex order 26.4b1

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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 16	F 658		

A review of Resident #18's Quarterly Minimum Data Set (MDS), (an assessment tool used to facilitate the management of care, in accordance with federal guidelines) indicated that the NJ ex order 26.4b [redacted]

A review of Resident #18's Electronic Medical Record (EMR) POs for the month of September revealed the following orders, 'NJ ex order 26.4b1 [redacted]

On 9/22/2023 at 10:37 AM, the surveyor conducted a phone interview with LPN #2, who was Resident #18's nurse on NJ ex order 26.4b1 and NJ ex order 26.4b1, when the NJ ex order 26.4b1 was started during the 3 PM to 11 PM shift. LPN #2 acknowledged that she forgot to label the water NJ ex order 26.4b1 during the evening shift of NJ ex order 26.4b1 and the NJ ex order 26.4b1 during the evening shift of NJ ex order 26.4b1. LPN #2 identified that the NJ ex order 26.4b1 labels should include: the resident's name, room number, date, NJ ex order 26.4b1 .

On 9/22/2023 the surveyor reviewed the facility policy titled, Enteral Tube Feeding via Continuous Pump. Under the general guidelines section of the policy it states, "3. Check the enteral nutrition label against the order before administration. Check the following information: a. Resident name, ID, and room number; b. type of formula; c date and time formula were prepared, g. rate of administration (ml/hr.)." Under the initiate feeding

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 10/02/2023

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 658	Continued From page 17	F 658		

section of the policy it states, "On the formula label document initials, date and time the formula was hung/administrated."

On 9/27/2023 at 1:37 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Regional Director of Nursing (DON) to discuss our concerns. The LHNA stated that both the NJ ex order 26.4b1 [redacted] should have been properly labeled. No further information was provided.
2. On 9/21/23 at 10:51 AM, the surveyor observed Resident #135 in the day room seated in a chair.

The surveyor reviewed Resident #135's hybrid medical records.

Review of Resident #135's FS reveals that the resident was admitted to the facility with diagnosis that included but were not limited to NJ ex order 26.4b1 [redacted].

A review of the NJ ex order 26.4b Quarterly MDS reflected that the resident had a Brief Interview for Mental Status (BIMS) of [redacted] out of 15, indicating that the resident had a NJ Exec. Order 26:4.b.1 .

A review of the electronic PO for NJ ex order 26.4b1 reflected a PO dated NJ ex order 26.4b for a NJ ex order 26.4b1 [redacted]

A review of the electronic Medication Administration Record (eMAR) for NJ ex order 26.4b1 [redacted] reflected that the medication NJ ex order 26.4b1

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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 18 was to be administered PRN (as needed). The eMAR reflected that the NJ ex order 26.4b1 was not administered when Resident #135's NJ ex order 26.4b1 [redacted] A review of the NJ ex order 26.4b1 eMAR revealed that the medication was not administered for 4 different occasions when the resident's NJ ex order 26.4b1. On 9/26/23 at 11:40 AM, the surveyor interviewed LPN#2 who was taking care of Resident #135. LPN#2 stated that the BP was checked every shift and the medication should have been administered on those days when the NJ ex order 26.4b [redacted]. On 9/27/23 at 1:30 PM, the survey team met with the LNHA and the DON to discuss the above concerns. There was no further information provided.	F 658		
F 688 SS=D	NJAC 8:39- 29.2 (d) Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 688		11/3/23

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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	50 POLIFLY ROAD HACKENSACK, NJ 07601

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F 688	Continued From page 19 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately assess and implement interventions for the care and management of a resident with a NJ Exec. Order 26:4.b.1 for 1 of 1 resident, Resident #48, reviewed for rehab and restorative services. This deficient practice was evidenced by the following: On 9/21/23 at 11:13 AM, the surveyor observed Resident #48 NJ ex order 26.4b1, alert and conversant. The NJ ex order 26.4b1 The NJ ex order 26.4b1 . Resident #48 informed the surveyor that they NJ ex order 26.4b1 The resident explained that they NJ ex orde and were not sure what the future plans for their care was. The surveyor reviewed the electronic health record (EHR) of Resident #48 revealed the following: According to the Admission Record, the resident was admitted with diagnoses that included but	F 688	Upon notification all residents on restorative nursing program for splinting were reviewed to ensure orders were in place with care plans and splint was being applied. R45 was screened by NJ Exec. Orde All residents on restorative nursing with splinting have the potential to be affected by this deficient practice. DON and Rehabilitation Director educated nursing and rehab staff regarding restorative nursing program, splinting orders, and application of splints. DON/Designee will audit restorative splinting list weekly to ensure orders are in place and ensure splint application by reviewing TAR and rounding to ensure splint application for 4 weeks and monthly thereafter for 2 months. The results of the audits will be presented at the monthly QAPI meetings.	

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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	50 POLIFLY ROAD HACKENSACK, NJ 07601

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F 688	Continued From page 20	F 688		

were not limited to, NJ ex order 26.4b1 [redacted]

A Quarterly Minimum Data Set (MDS) assessment dated NJ ex order 26.4b1 revealed that the facility performed a Brief Interview for Mental Status (BIMS) which indicated that Resident #48 had a score of NJ ex out of 15. The resident was assessed to be NJ Exec. Order 26:4.b.1. The assessment also indicated that the resident NJ ex order 26.4b1 [redacted]

A physician's order dated NJ ex order 26.4b1 read, NJ ex order 26.4b1 [redacted]."

A physician's order dated NJ ex order 26.4b1 read, "NJ ex order 26.4b1 [redacted]"

There were no active physician orders for restorative nursing services or hand splint.

A review of the NJ ex order 26.4b1 electronic medication administration record (eMAR) and electronic treatment administration record (eTAR) revealed no entries for restorative nursing exercises or hand splint.

A review of the care plan (CP) with a focus that read, "[Resident #48] is NJ ex order 26.4b1 [redacted] The CP included interventions that read, "[Resident #48] will NJ ex order 26.4b1 [redacted]

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 10/02/2023

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 688	Continued From page 21	F 688		

NJ ex order 26.4b1 ."

On 9/22/23 at 1:12 PM, the surveyor interviewed the Certified Nurse Aide (CNA) in reference to restorative nursing. The CNA stated that there were specific aides who were assigned to provide restorative nursing exercises to the residents on the unit. The CNA could not specify which staff were responsible explaining that a restorative nursing binder could be found at the nurses' station. The CNA stated Resident #48's NJ Exec. Order 26:4.b , and she did not know if the resident was receiving restorative nursing care.

On 9/22/23 at 1:21 PM, the surveyor reviewed the resident's paper chart at the nurses' station which revealed a NJ ex order 26.4b1 for Resident #48. The forms documented the NJ Exec. Order 26:4.b.1 that Resident #48 was NJ ex order 26.4b1 .

The NJ ex order 26.4b1 form documented restorative care performed from NJ ex order 26.4b1 , with no further entries. The surveyor reviewed the restorative nursing binder at the nurses' station, which revealed there was no NJ ex order 26.4b1 "NJ ex order 26.4b1 " form for Resident #48.

On 9/25/23 at 12:00 PM, Resident #48 was observed lying in bed in their room. The surveyor observed a NJ ex order 26.4b1 and asked the resident about it. Resident #48 explained that it was used on their NJ ex order 26.4b1 , and NJ ex order 26.4b1

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 10/02/2023

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 688	Continued From page 22	F 688		

NJ ex order 26.4b1 . The resident stated that NJ ex order 26.4b1 . Resident #48 further stated no one had come to perform any NJ ex order 26.4b1 .

On 9/25/23 at 12:42 PM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM) about NJ ex order 26.4b1 . The LPN/UM stated when a resident was NJ ex order 26.4b1 , recommendations for NJ ex order 26.4b1 would be provided by the rehab department.

The LPN/UM explained that a NJ ex order 26.4b1) staff member would educate the nurses and CNAs about the restorative nursing recommendations and the unit manager would sign off that education was provided. The LPN/UM revealed that the restorative aide on the unit was responsible for providing NJ ex order 26.4b1 and signing off in the restorative nursing binder that it was completed. The LPN/UM explained that recommendations for NJ ex order 26.4b1 under the physician's orders. For a resident using a NJ ex order , the nurses would sign in the eMAR or eTAR documenting that the hand splint was applied.

The surveyor and LPN/UM discussed the NJ ex order and that there were no orders found for the resident. The LPN/UM could not recall if she ever saw the NJ ex order 26.4b1 . She was not sure if the resident was currently receiving PT/OT services or NJ ex order 26.4b1 as well.

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 10/02/2023

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 688	Continued From page 23	F 688		

On 9/26/23 at 10:10 AM, the acting Director of Nursing (DON) provided OT notes for February 2023 to March 2023 as well as notes that indicated the resident was NJ ex order 26.4b1 on NJ ex order 26.4b.

On 9/26/23 at 12:07 PM, the Rehab. Director, Rehab. Supervisor, and the DON met with the surveyor. The Rehab. Director provided documentation which included a NJ Exec. Order 26:4.b.1, dated NJ ex order 26, recommending the resident for skilled PT services. The Rehab. Director stated the resident was NJ ex order 26.4b1 with restorative nursing recommendations to continue, previous NJ Exec. Order 26:4.b) NJ ex order 26.4b1 he DON acknowledged that the recommendations provided by Rehab. were not followed up or carried out by nursing.

On 9/26/23 at 12:17 PM, the Rehab. Director provided the surveyor the document titled "In-service form", dated NJ ex order 26.4b which indicated recommendations for restorative nursing NJ ex order to be performed with Resident #48, which included instructions for NJ ex order 26.4b1. This form was signed by the LPN/UM, indicating the in-service was provided. There was no documentation provided that the resident received NJ ex order 26.4b1 or that the NJ ex order 26.4b1 was being applied to the resident. The Rehab. Director stated it was the responsibility of nursing to ensure that the recommendations were carried out and documentation was completed in the restorative nursing binder on the unit.

On 9/26/23 at 12:50 PM, the surveyor interviewed the LPN/UM who acknowledged it was nursing's

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 10/02/2023

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 688	Continued From page 24	F 688		

responsibility to ensure restorative nursing recommendations were being carried out and services were being provided to the residents.

On 9/26/23 at 12:53 PM, the surveyor interviewed the restorative nursing aide (RNA), who stated that he was informed by PT/OT as to which residents received restorative nursing services. The RNA explained that he would sign the restorative nursing binder after NJ ex order 26.4b1 [redacted] were completed with the resident. The RNA stated it had been a while, approximately 2 months since he had last provided NJ ex order 26.4b1 [redacted] to Resident #48.

A review of the facility's policy, "Prosthetic and Splint", dated 5/2023, under Policy Interpretation and Implementation read, " 1) Patients will be evaluated by Physical Therapy and/or Occupational Therapy for any custom-made or prefabricated prosthetic and splint ...2) A prosthetic or splint is medically necessary if it is needed to maintain or improve the patient's medical, physical, or functional level. This includes when they are required to correct or prevent skeletal deformities, to support or align movable body parts, or to preserver or improve physical function."

A review of the facility's policy, "Restorative Nursing Services", dated 10/2019, under Policy Statement read, "Residents will receive restorative nursing care as needed to help promote optimal safety and independence." Under Policy Interpretation and Implementation, it read : "1. Restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitation services (e.g., physical, occupation or speech therapies)."

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 10/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 688	Continued From page 25 The policy did not further address the procedure for carrying out recommendations or who was responsible for providing restorative nursing services. On 9/27/23 at 1:54 PM, the surveyor informed the Licensed Nursing Home Administrator and the DON about the concerns involving the [redacted] On 9/28/23 at 11:14 AM, the DON established that there was no documentation that Resident #48 received NJ ex order 26.4b1 or that the NJ ex order 26.4b1 was being applied to the resident after [redacted]. No further documentation was provided. N.J.A.C. 8:39-27.1(a); 27.2(m)	F 688		
F 761 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 §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.	F 761		11/3/23

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 10/02/2023

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 761	Continued From page 26 §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 record review, it was determined that the facility failed to secure stored controlled medications, as well as ensure that expired, and discontinued medications were removed from the medication cart in a timely manner. This deficient practice was identified in 3 of 3 facility units inspected. The deficient practice was evidenced by the following: 1. On 9/20/23 at 12:15 PM, the surveyor inspecting the 2nd floor refrigerator. The Narcotic Plastic Lock Box located in the 2nd floor refrigerator was secured to the shelf via a metal chain link and keyed lock. The metal link chain was loosely attached, which allowed the surveyor to insert her hand into the box and remove the control substances (medications that are rated by their abuse risk and placed in Schedules by the Federal Drug Enforcement Administration) stored inside of the box. The controlled substances found in the box were Lorazepam (anxiolytic, sedative) 2mg/milliliters (ml) 30 ml bottle, #20 gel tabs delivered to the facility on 9/19/28 and #3 gel tabs delivered to the facility on 9/11/23 of Dronabinol (orally active	F 761	Upon notification narcotic box on 2nd floor was a second narcotic box and was removed from the refrigerator as it was not needed. Other refrigerators were inspected and any narcotic box not properly affixed and not in use was removed. All medication carts inspected and discontinued and/or expired medications were removed and destroyed as per facility policy. All residents receiving medication have the potential to be affected by this deficient practice. DON and Facility Educator educated nursing staff on securing of narcotics, removing expired and discontinued medications from medication cart. DON/Designee will audit all medication carts weekly for 4 weeks then monthly for 2 months that all expired or discontinued medications are removed from medication carts. DON/ Designee will also audit the medication refrigerators to ensure narcotic boxes are secured appropriately. The results of the audits will be presented	

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

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F 761	Continued From page 27 cannabinoid used for nausea, vomiting, loss of appetite and weight loss) 2.5 mg. 2. On 9/20/23 at 12:40 PM, the surveyor inspected the 3rd floor medication cart A. The surveyor found Admelog Insulin 100 u/ml opened 7/28/23 with a 28 day discard date of 8/25/23. The surveyor also found Aspirin Low Dose Chewable 81 mg with a documented expiration date printed on the bottle of 8/2023. Also found in the medication cart was a bottle of Sore throat Spray delivered from the pharmacy to the facility on 12/10/22 with a printed "use by date" printed on the label of 12/9/23. This bottle of Sore throat Spray was never opened. Review of August 2023 and September 2023 revealed that the Physician's order with a physician's order date of 12/10/22, documented on the electronic medication administration record (eMAR) was, "SORE THROAT SPRAY 1.4% Apply to throat topically as needed for sore throat" with no documented use of the medication. 3. On 9/20/23 at 12:40 PM, the surveyor inspecting the 4th floor medication cart A. The surveyor found Ultra Lubricating Eye Drops 15 ml delivered to the facility by the pharmacy on 5/2/23 and opened on 5/13/23. The Ultra Lubricating Eye Drops were ordered by the physician as, "ULTRA EYE DROP 0.4-0.3% Instill 1 drop in both eyes every 8 hours as needed for dry eyes," and documented on the July 2023 eMAR as discontinued for use by the physician on 7/16/23. The surveyor reviewed the 7/28/23 and 8/22/23 Monthly Nursing Station Inspection Medication	F 761	at monthly QAPI meetings.	

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F 761	Continued From page 28	F 761		

Storage and Labeling created by the Consultant Pharmacist after their monthly inspections. Both reports documented the removal of expired medications from the medication carts and the refrigerators on all 3 floors.

Review of the facility Discontinued Medications policy presented, "3. Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies."

On 9/21/23 at 12:48 PM, the surveyor discussed the unit inspection findings with the Consultant Pharmacist. He could not explain why the listed items were not removed during unit inspections by the Consultant Pharmacist during their monthly review.

On 9/27/23 at 11:10 AM, the Acting Director of Nursing informed the surveyor that the 11-7 shift nurses as well as all nurses are responsible for examining the medication carts for expired and discontinued medications during their shift. The DON stated that all expired medications should be removed by nursing once they get close to the expiration date. The DON added that all discontinued medications should be removed by nursing from the medication cart once the order is discontinued by the physician. The DON added that all medications ordered that have not been used should be discontinued and removed from the medication cart.

On 9/27/23 at 1:30 PM, the surveyor once again discussed the above observations and concerns with the facility's Licensed Nursing Home Administrator and DON. No further information was provided.

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F 761	Continued From page 29 NJAC 8:39-29.4(h)	F 761		

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	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 observation, 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. 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;	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 fulltime were scheduled to meet minimum staff to resident ratios. Licenses/ certifications were verified by the staffing manager/ Human Resources for current licensed certified staff. DON / Designee to in-service 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 Scheduling manager 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 QAPI monthly.	11/3/23

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S 560	Continued From page 1 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 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 2-week period beginning 9/3/23 to 9/9/23 and ending 9/10/23 to 9/16/23 revealed the facility was not in compliance with the State of New Jersey	S 560		

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S 560	Continued From page 2	S 560		

minimum staffing requirements in CNAs to total staff on 14 of 14 day shifts as follows:
For the 2 weeks of staffing 9/3/2023 to 9/9/2023 and 9/10/2023 to 9/16/2023 the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-09/03/23 had 10 CNAs for 151 residents on the day shift, required at least 19 CNAs
-09/04/23 had 12 CNAs for 151 residents on the day shift, required at least 19 CNAs.
-09/05/23 had 14 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/06/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/07/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/08/23 had 14 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/09/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/10/23 had 11 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/11/23 had 15 CNAs for 151 residents on the day shift, required at least 19 CNAs.
-09/12/23 had 14 CNAs for 149 residents on the day shift, required at least 19 CNAs.
-09/13/23 had 12 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/14/23 had 15 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/15/23 had 13 CNAs for 148 residents on the day shift, required at least 18 CNAs.
-09/16/23 had 8 CNAs for 148 residents on the day shift, required at least 18 CNAs.

The facility's Licensed Nursing Home Administrator, Director of Nursing, and Regional Administrator were informed of their deficient practice on 9/21/23 at 1:15 PM. No further

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S 560	Continued From page 3 information was provided	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
315295 Y1	A. Building B. Wing Y2	12/1/2023 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 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 F0640	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	11/03/2023	LSC	11/03/2023	LSC	11/03/2023
ID Prefix F0688	Correction	ID Prefix F0761	Correction	ID Prefix	Correction
Reg. # 483.25(c)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed
LSC	11/03/2023	LSC	11/03/2023	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	
10/2/2023	☐ 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
060231 Y1	A. Building B. Wing Y2	12/1/2023 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	11/03/2023	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	
10/2/2023	☐ 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
	315295	A. BUILDING **01** B. WING _____	**10/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	**50 POLIFLY ROAD** **HACKENSACK, NJ 07601**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 09/28/2023. 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, Health Facility Survey and Field Operations on 09/28/23 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 Regent is a five-story building that was built in 1988. Skilled nursing is located on the second, third, and fourth floors. It is composed of Type II protected construction. The facility is divided into nine - smoke zones. The generator does approximately 50% of the building as per the Maintenance Director. The current occupied beds are 151 of 180.	K 000		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke	K 223		11/3/23

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

Electronically Signed | 10/26/2023

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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K 223	Continued From page 1 compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure any door in a hazardous area was held open only by an automatic release device in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.2.2.2.7. This deficient practice could affect 58 residents. Findings include: Observation on 09/28/23 at 2:26 PM revealed the door to the Medical Records Room, located on the second floor, was held open by a door wedge. The Medical Records Room was larger than 50 square feet and contained a large quantity of medical records. During an interview at the time of the observation, the Maintenance Director confirmed the Medical Records door was held open by a door wedge.	K 223	The medical records door wedge was immediately removed and the door was closed. 58 residents can be affected by this deficient practice. All other doors were checked to ensure that door wedges were not present and the doors that are required to be shut were closed. The medical records staff was educated on ensuring that the door to the medical records office is not wedged open. The maintenance director or his/her designee will audit 2 doors twice weekly for 4 weeks and twice monthly for 2 months to ensure that doors are closed properly and not wedged open. All findings will be reviewed by the QAPI committee monthly.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code,	K 341		11/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315295	A. BUILDING **01** B. WING _____	**10/02/2023**

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
K 341	Continued From page 2 and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure automatic smoke detection was provided at the location of the fire alarm control unit in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 10.15. This deficient practice could affect all 151 residents. Findings include: Observation on 09/28/23 at 2:49 PM revealed the fire alarm control unit was in an alcove on the ground floor in the lobby. The lobby was not continuously occupied, and automatic smoke detection was not provided in the alcove. During an interview at the time of the observation, the Maintenance Director confirmed the fire alarm control unit was not provided with smoke detection.	K 341	A fire alarm automatic smoke detector was installed in the alcove in the ground floor of the lobby. All residents can be affected by this deficient practice. All other areas of the facility were audited to ensure that a fire alarm automatic smoke detector was installed in an area that is not continuously occupied. The maintenance director was educated on the requirement for smoke detection in any area that is not continuously occupied. The maintenance director will test the smoke detector monthly for two months to ensure that it properly functions as required. All findings will be reviewed by the QAPI committee monthly.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance	K 345		11/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315295	A. BUILDING **01** B. WING _____	**10/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	**50 POLIFLY ROAD** **HACKENSACK, NJ 07601**

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K 345	Continued From page 3 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. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the fire alarm system and components were tested and maintained in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 9.6.1.3. This deficient practice had the potential to affect all 151 residents. Findings include: Document review of the facility's inspection binder provided by the Maintenance Director revealed fire alarm inspections were conducted on 1/28/22 and 12/13/22. The fire alarm was not inspected on a semi-annual basis and there was no documentation to indicate a smoke detector sensitivity test had been conducted. During an interview 09/28/23 at 3:30 PM, the Maintenance Director confirmed the fire alarm system was not inspected on a semi-annual basis and a smoke detector sensitivity test had not been conducted. He stated the facility was recently bought by another company and they did not realize the sprinkler systems inspections and smoke detector sensitivity test had not been	K 345	A Semi annual inspection on the fire alarm and a smoke detector sensitivity test were performed. All residents can be affected by this deficient practice. The maintenance director was reeducated on required fire alarm testing and smoke sensitivity testing. The Administrator or his/her designee will audit the fire alarm system testing logs monthly for 3 months to ensure that all necessary inspections are completed. All findings will be reviewed by the QAPI committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315295	A. BUILDING **01** B. WING _____	**10/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	**50 POLIFLY ROAD** **HACKENSACK, NJ 07601**

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K 345	Continued From page 4 conducted.	K 345		
K 353 SS=F	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 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure the sprinkler system was tested and maintained in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 9.7.5. This deficient practice had the potential to affect all 151 residents. Findings include: Document review of the facility's inspection binder provided by the Maintenance Director revealed sprinkler systems inspections were conducted on 1/28/22, 4/25/22, and 12/13/22. The sprinkler	K 353	A sprinkler system inspection was conducted and was in compliance. All residents have the potential to be affected by this deficient practice. The maintenance director was reeducated on required sprinkler system inspections. The Administrator or his/her designee will audit the sprinkler system testing logs monthly for 3 months to ensure that all necessary inspections are completed. All	11/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315295	A. BUILDING **01** B. WING _____	**10/02/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT REGENT LLC	**50 POLIFLY ROAD** **HACKENSACK, NJ 07601**

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K 353	Continued From page 5 system was not inspected on a quarterly basis. During an interview 09/28/23 at 3:30 PM, the Maintenance Director confirmed the sprinkler system was not inspected on a quarterly basis. He stated the facility was recently bought by another company and they did not realize the sprinkler system inspections had not been conducted.	K 353	findings will be reviewed by the QAPI committee monthly.	

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
315295 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/1/2023 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 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 K0223	11/03/2023	LSC K0341	11/30/2023	LSC K0345	11/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0353	11/30/2023	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	
10/2/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO