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	02/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Regent LLC	50 Polifly Road Hackensack, NJ 07601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46049 Based on observation, interview, and record review, it was determined that the facility failed to ensure that the resident's call light was readily accessible within reach. The deficient practice was identified for 1 of 1 resident, Resident #309, reviewed for accommodation of needs. This deficient practice was evidenced by the following: On 1/27/25 at 10:27 AM, the surveyor observed the resident resting in bed, alert, soft spoken, and verbally responsive. The surveyor observed the resident's call light was tied to the left siderail, dangling down towards the floor and not clipped onto the bed within the resident's reach. The surveyor asked Resident #309 about call bell use, and the resident replied that sometimes they could not reach the call bell and stated, like now I don't know where my call bell is. At that same time, the surveyor notified the resident where their call bell was and asked if they could reach it. Resident #309 replied No .I can't even see where it is. The surveyor asked Resident #309 what would happen in those instances where they could not find their call bell and needed staff assistance. The resident replied they would try to shout out or usually would have to wait for staff to come to their room. On 1/27/25 at 10:30 AM, the surveyor interviewed the Registered Nurse (RN) who was assigned to care for Resident #309. The RN stated the resident needed staff assistance for activities of daily living (ADLs). The RN further explained that the resident was able to use the call bell to call for staff assistance. The RN acknowledged a call bell should be within the resident's reach. The surveyor notified the RN of the concern for the observation of the resident's call bell. Afterward, the RN went to the resident's room to observe the call bell. The surveyor observed the RN asked Resident #309 if they needed anything and clipped the call bell within the reach of the resident. On 1/29/25 at 9:21 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #309. The Admission Record (a summary of important information about the resident) revealed that Resident #309 had diagnoses that included, but were not limited to, chronic kidney disease, muscle weakness, and diabetes mellitus. (continued on next page)

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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS), an assessment tool used, with an assessment reference date (ARD) of 11/22/24, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which reflected that the resident was cognitively intact. A care plan with a focus for risk for falls included an intervention that indicated be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed and the resident needs prompt response to all requests for assistance with date initiated on 12/26/24. On 1/30/25 at 2:16 PM, the surveyor notified the Director of Nursing (DON) and the [NAME] President of Clinical Services (VPoCS) about the concern of the resident's call bell not being within their reach. On 2/3/25 at 10:32 AM, the Licensed Nursing Home Administrator, the DON, and the VPoCS met with the survey team. The VPoCS stated that the RN immediately went into the room to ensure the resident's call bell was within reach and education was provided to staff on ensuring call bells were within the reach of a resident. A review of the facility's Call Lights Policy with a last updated date of January 2025, revealed under procedure #6. Always position call light conveniently for use and within the reach of the resident . NJAC 8:39-27.1 (a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49078 Based on observation, interview, and review of other facility documentation, it was determined the facility failed to ensure the facility was maintained in a safe, clean, and homelike environment. This deficient practice was identified for 3 of 3 units, (2nd, 3rd, and 4th units) and 2 of 2 residents' rooms. This deficient practice was evidenced by the following: 1. On 1/27/25 at 1:58 PM, during the initial tour of the 4th floor nursing unit, the surveyor observed a gray, dust or dirt-like substance adhering to the air circulation vent covers on the 4th floor unit in the hallways and above the nursing station. The surveyor observed four vent covers in the 4th floor hallways and one vent cover above the nursing station. On 1/28/25 at 9:30 AM, the surveyor observed the vent covers on the 2nd and 3rd floors. The surveyor observed that the vent covers on the 2nd and 3rd floors also had a gray, dust or dirt-like substance accumulated on them. The surveyor asked the Director of Nursing (DON) who was responsible for the cleaning of the air vents. The DON stated that maintenance was the department responsible. On 1/28/25 at 10:27 AM, the surveyor interviewed the Director of Maintenance (DM) on the 4th floor. The surveyor asked the DM if the maintenance department was responsible for cleaning the air vents and when was it done. The DM stated, yes, it was done by maintenance and should be done monthly. On that same date and time, the surveyor showed the DM the air vents located on the 4th floor and asked if they were considered clean. The DM stated no, they do not look clean. The surveyor asked if the amount of material on the vents looked like it could accumulate within a few days. The DM stated, no, it would take a while to build up. The surveyor asked if the condition of the air vents would be considered homelike, clean and sanitary. The DM stated no they were not. The surveyor asked the DM if it was likely that the air vents on the other floors were in the same condition. The DM stated, they probably were dirty as well, I have to check with my staff to see why they were not being cleaned, they should be cleaned with a vacuum. On 1/28/25 at 2:00 PM, the survey team met with the DON, Assistant Director of Nursing (ADON), Licensed Nursing Home Administrator (LNHA) and [NAME] President of Clinical Services (VPoCS) to discuss concerns. The facility did not provide any further pertinent documentation. 38327 2. On 1/27/25 at 10:58 AM, during the initial tour, the surveyor observed room [ROOM NUMBER]'s toilet vent with an accumulation of grayish substances. At that time, there were two residents inside the room, Resident # 23 and Resident # 8. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/28/25 at 11:21 AM, the surveyor with the Registered Nurse (RN) went to see room [ROOM NUMBER]'s toilet and both observed an accumulation of grayish substances on the vent. The RN stated that the vent should have been cleaned by housekeeping, and she confirmed that the grayish substances were the accumulation of dust. 3. On 1/27/25 at 10:59 AM, during the initial tour, the surveyor observed room [ROOM NUMBER]'s toilet tissue paper holder broken. The surveyor observed Resident #12 was inside the room seated on the side of the bed. On 1/28/25 at 11:13 AM, the surveyor observed Resident #12 lying on the bed, awake, and denied care concerns. The surveyor observed the toilet room with broken tissue paper holder, same as yesterday's observation. 4. On 1/28/25 at 10:42 AM, the surveyor observed the elevator vent with an accumulation of grayish substances. At that same time, the staff and a resident were inside the elevator. On 1/29/25 at 1:16 PM, the survey team met with the LNHA, DON, and VPoCS. The VPoCS stated that we addressed the vents and put the process in place for cleaning. The surveyor notified the concern also with the elevator's dusty vents, and the VPoCS responded that she would look at it as well. On 2/03/25 at 8:22 AM, the surveyor followed up the concerns with Resident #12's broken toilet tissue paper holder and the elevator vent, and the DON responded that resident#12's toilet tissue paper holder was done and fixed the same day the surveyor mentioned it. He further stated that the concerns with dusty vents in the elevator and room [ROOM NUMBER] toilet were all cleaned after the surveyor's inquiry. A review of the facility's Environment Policy, with a reviewed date of 1/2025, that was provided by the VPoCS on 1/30/25 at 10:10 AM revealed: In accordance with residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment . Definitions: Environment refers to any environment in the facility that is frequented by residents, including the residents' rooms, bathrooms, hallways, dining areas, lobby, outdoor patios, therapy areas, and activity areas . Orderly is defined as an uncluttered physical environment that is neat and well-kept . Policy Explanation and Compliance Guidelines: 3. Housekeeping and Maintenance services will be provided as necessary to maintain a sanitary, orderly, and comfortable environment . The policy did not reflect any mention of air vents, cleaning of vents or other areas. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/03/25 at 12:05 PM, the survey team met with the LNHA, DON, and VPoCS for an exit conference, and there was no additional information provided by the facility. NJAC 8:39-31.4(a)(b)(f)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885 Based on interview and review of pertinent documentation provided by the facility, it was determined that the facility failed to ensure licensed staff credentials were verified upon hire. This deficient practice was identified for 5 of 8 newly hired licensed staff reviewed, Staff Member (SM) #1, #4, #5, #6, and #7 evidenced by the following: On 1/28/25 at 11:12 AM, the surveyor reviewed ten randomly selected newly hired employee files. The review for license verification for eight of the new licensed employees revealed the following: 1. A review of Staff Member #1 (SM#1), a Certified Nursing Assistant (CNA #1), hired on 5/30/24, had a New Jersey Department of Health (NJDOH) online Public Registry license verification printout (used to verify the status of a CNA's license and to check the nurse aide registry) which did not include the date that the verification was done. There was no documented evidence that SM#1's license was verified prior to the date of hire (doh). 2. A review of Staff Member #4 (SM#4), a CNA, hired on 6/20/24, had a NJDOH online Public Registry license verification printout which did not include the date that the verification was done. There was no documented evidence that SM#4's license was verified prior to the doh. 3. A review of Staff Member #5 (SM#5), a CNA, hired on 6/13/24, had a NJDOH online Public Registry license verification printout which did not include the date that the verification was done. There was no documented evidence that SM#5's license was verified prior to the doh. 4. A review of Staff Member #6 (SM#6), a CNA, hired on 2/22/24, had a NJDOH online Public Registry license verification printout which did not include the date that the verification was done. There was no documented evidence that SM#6's license was verified prior to the doh. 5. A review of Staff Member #7 (SM#7), a CNA, hired on 9/20/24, had a NJDOH online Public Registry license verification printout which did not include the date that the verification was done. There was no documented evidence that SM#7's license was verified prior to the doh. On 1/28/25 at 12:28 PM, the surveyor interviewed the Director of Human Resources ([NAME]) regarding the process for license verification. The [NAME] stated that she would ask for a copy of their license and verify it on the NJDOH online Public Registry prior to the doh. The surveyor asked if the date that the verification was on the printout. The [NAME] stated that she was not sure. The [NAME] then viewed one of the printouts and stated that she did not think the date was on the printout. On 1/29/25 at 10:07 AM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Regional LNHA, Director of Nursing (DON) and [NAME] President of Clinical Services (VPoCS) the concern that SM#1, SM#4, SM#5, SM#6 and SM#7 did not have documented evidence of the date that their license was verified. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/25 at 1:41 PM, in the presence of the LNHA and DON, the VPoCS stated that she called the license verification site and they stated that the date was not printed from the website and that the computer that is printing it would have to have the header and footer setting for the date to be printed on the printout. She added that she did not know that. The VPoCS stated that we verify license prior to the doh and that it was part of their process. The facility could not provide documented evidence that the licenses were verified prior to their doh. The facility did not provide any additional information. A review of the facility's Abuse, Neglect and Exploitation Policy with a adopted date of 6/2024, included the following: A. Potential employees will be screened for a history of abuse, neglect, exploitation, or misappropriation of resident property. 1. Background, reference, and credential's checks shall be conducted on potential employees 3. The facility will maintain documentation of proof that the screening occurred. A review of the facility's Onboarding/Background Check Policy and Procedure with a revised date of 10/2024, included the following: License/Certification Verification: confirms the applicant's license/certification is in good standing with no pending or prior investigations. (if applicable) N.J.A.C. 8:39-43.15(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38327 REPEAT DEFICIENCY Based on 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 3 of 34 residents, (Residents #23, #308, and #309), reviewed for accuracy for MDS coding. This deficient practice was evidenced by the following: 1. On 1/27/25 at 10:59 AM, the surveyor observed Resident #23 lying on the bed with BIPAP (Bilevel positive airway pressure, is a machine that helps resident breathe and a form of noninvasive ventilation) and nebulizer machine on top of the nightstand table. On 1/28/25 at 11:16 AM, the surveyor observed the resident lying on the bed, and informed the surveyor that they use the oxygen (O2) as PRN (as needed) and the BIPAP at night. The surveyor reviewed the medical records of Resident #23, and revealed: The Admission Record (AR, an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts) and chronic obstructive pulmonary disease (COPD, is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough) unspecified. A review of the most recent comprehensive MDS (cMDS), with an assessment reference date (ARD) of 9/13/24, Section C Cognitive Patterns, a brief interview for mental status (BIMS) score of 15 out of 15, which reflected that the resident's cognition was intact. Section O Special Treatments, Procedures, and Programs reflected that O2 and non-invasive mechanical ventilators were not coded. Further review of the medical record revealed on ARD 12/6/24, the most recent quarterly MDS, with a BIMS score of 15 out of 15, which reflected that the resident's cognition was intact. Section O reflected that O2 was not coded. A review of the Order Summary Report (OSR) revealed a Physician Order (PO) dated 7/18/24, to apply BIPAP settings: 18/6 FIO2 (fraction of inspired O2 (FiO2) is the concentration of O2 in the gas mixture) 30%, frequency: on at HS (hours of sleep, also known as bedtime) and off in the AM (morning) for hypercapnia (a condition that occurs when a person has too much carbon dioxide in their bloodstream) and remove per schedule. The above order for BIPAP was transcribed to the electronic Treatment Administration Record (eTAR) and signed by nurses as administered, at 9:00 PM and removed at 8:00 AM for September, October, November, December 2024, and January 2025. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 8:32 AM, the surveyor interviewed the Registered Nurse/MDS Supervisor (RN/MDSS), who informed the surveyor that there was no separate policy for MDS, and that the facility followed the RAI (Resident Assessment Instrument) manual. The RN/MDSS informed the surveyor that Section O in MDS should be coded for O2 if there was an order for O2 and BIPAP. The RN/MDSS further stated that she would get back to the surveyor as to why the 9/13/24 MDS was not coded for O2 and BIPAP, and the 12/6/24 MDS was not coded for O2. On 2/3/25 at 10:32 AM, the RN/MDSS stated that the MDSs ARD 9/13/24 and 12/6/24 were miscoded. On 2/3/25 at 12:05 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and [NAME] President of Clinical Services (VPoCS) for an exit conference, and there was no additional information provided by the facility. 46049 2. On 1/28/25 at 9:21 AM, the surveyor reviewed the electronic medical record (EMR) of Resident #309. The AR revealed that Resident #309 had diagnoses that included, but were not limited to, chronic kidney disease, muscle weakness, and diabetes mellitus. A review of the cMDS with an ARD of 8/24/24, revealed under section M (Skin Conditions), the resident was coded as having a diabetic foot ulcer. No other skin conditions were coded. A review of a nursing assessment note, dated 8/17/24, documented the resident had a wound to the sacral area. There was no documentation of a diabetic foot ulcer. A review of PO for August 2024 revealed there was no treatment order for a diabetic foot ulcer. A review of a wound consultant note dated 8/20/24, revealed no assessment or recommendation for treatment for a diabetic foot ulcer. On 1/29/25 at 2:18 PM, the surveyor interviewed the RN/MDSS who stated if the resident had an incontinence associated dermatitis (IAD) wound within the 7 day look back of the ARD, it should be coded on the MDS. The surveyor notified the RN/MDSS of the concern that the resident had a sacral wound upon admission which was not coded on the MDS. Additionally, the resident was coded as having a diabetic foot ulcer and review of MDS indicated the resident did not have one at time of MDS. The RN/MDSS stated she would review the EMR and provide further information to the surveyor. On 1/30/25 at 11:14 AM, the RN/MDSS informed the surveyor she reviewed the EMR of Resident #309 and confirmed the MDS was miscoded. The RN/MDSS stated the MDS was modified to reflect that the resident had a sacral IAD wound and that there was no diabetic foot ulcer to be coded. On 1/30/25 at 2:16 PM, the surveyor notified the DON and VPoCS of the above concern for the MDS accuracy. The facility was aware and confirmed the RN/MDSS modified the MDS assessment. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 10:32 AM, the LNHA, the DON, and the VPoCS met with the survey team. The DON and VPoCS stated the staff followed the MDS 3.0 Manual [Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual] and that there was no facility MDS policy. There was no additional information provided by the facility. A review of the latest version of the MDS 3.0 Manual (updated October 2024), Chapter 3-page M-33, M1040 revealed: 1. Review the medical record, including skin care flow sheets or other skin tracking forms. 2. Speak with direct care staff and the treatment nurse to confirm conclusions from the medical record review. 3. Examine the resident and determine whether any ulcers, wounds, or skin problems are present . 3. On 1/30/25 at 12:27 PM, the surveyor reviewed the EMR and the paper chart of Resident #308. The AR revealed that Resident #308 had diagnoses that included, but were not limited to, chronic kidney disease, congestive heart failure, muscle weakness, and anemia. A review of the discharge MDS assessment with an ARD of 8/17/24, revealed under section A (Identification Information), the resident had a coded discharge date of [DATE]. A review of the progress note, dated 8/16/24, documented the resident left the facility with resident representative against medical advice (AMA). A review of the paper chart revealed a Release from Responsibility For Discharge form which indicated the resident left AMA on 8/16/24 from the facility. On 1/30/25 at 1:34 PM, the surveyor notified the RN/MDSS of the concern for the coding accuracy of Resident #308's discharge date . The RN/MDSS stated she would review the EMR and provide further information to the surveyor. On 1/30/25 at 2:16 PM the surveyor notified the DON and the VPoCS of the above concern for the MDS accuracy. The VPoCS stated the RN/MDSS made them aware and that she modified the MDS assessment to reflect the accurate discharge date . On 2/3/25 at 10:32 AM, the LNHA, the DON, and the VPoCS met with the survey team. The DON and VPoCS stated the staff followed the MDS 3.0 Manual and that there was no facility MDS policy. There was no additional information provided by the facility. A review of the latest version of the MDS 3.0 Manual (updated October 2024), Chapter 3-page A-41, under coding instructions for A2000 (discharge date) revealed: Enter the date the resident was discharged (whether or not return is anticipated). This is the date the resident leaves the facility . Discharge assessments, the discharge date (A2000) and ARD (A2300) must be the same date . (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain data from the medical, admissions or transfer records. NJAC 8:39-33.2 (d)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38327 Based on observations, interviews, review of medical records and facility documents, it was determined that the facility failed to develop and implement a comprehensive plan of care to meet residents' preferences and goals and address the resident's medical and psychosocial needs. This deficient practice was identified for 2 of 34 residents (Residents #8 and #146) reviewed for a care plan. This deficient practice was evidenced by the following: 1. On 1/27/25 at 10:58 AM, the surveyor observed Resident #8 lying on the bed with eyes closed with the call bell within reach. On 1/28/25 at 11:14 AM, the surveyor observed the resident lying in bed asleep. On 1/29/25 at 10:39 AM, the surveyor observed the Activities Aide Recreation (AAR) with a cart in the hallway near the resident's room. The surveyor interviewed the AAR, who informed the surveyor that she knew Resident #8 and the resident's preferences. She further stated that the resident preferred to sleep late at night and wake up late in the morning. She acknowledged that preference of the resident should be in the care plan (CP) in order to respect their wishes and to notify other staff who cared for the resident. On 1/29/25 at 12:57 AM, the surveyor interviewed the Certified Nursing Aide (CNA), who informed the surveyor that she knew Resident #8 from the other unit (4th floor) where the resident initially stayed, the resident had a behavior of being verbally abusive to staff and other residents, but the behavior was getting better, and resident gets along with the roommate now. She further stated that the resident was cognitively intact with some forgetfulness, and the resident's preferences were important to them. She further stated that the resident and the roommate preferred to watch television until 11:00 PM, get up at 8:00 AM for breakfast, and then around 10ish (10:00 AM), go back to sleep, then wake up again in the afternoon and attend activities. The surveyor reviewed the medical records of Resident #8, and revealed: A review of the Resident's Admission Record (AR, admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; essential hypertension (occurs when a resident has abnormally high blood pressure that was not the result of a medical condition), unspecified mood (affective) disorder, and depression unspecified. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with assessment reference date (ARD) 10/31/24, Section C Cognitive Skills with a brief interview for mental status (BIMS) score of 13 out of 15, which reflected that resident's cognition was intact. A review of the personalized CP revealed that there were plan of care documented to reflect and address the resident's preferences of staying late at night and waking up late. (continued on next page)

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	02/03/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/25 at 1:16 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and [NAME] President of Clinical Services (VPoCS), and the surveyor discussed the above findings and concerns with CP. The VPoCS stated that the resident usually sleeps after breakfast time and attends activities later in the afternoon. The surveyor asked was the resident's preferences reflected and addressed in the CP, and the VPoCS responded that it was not in the resident's CP. The DON stated that CP was initiated after the surveyor's inquiry. A review of the facility's Care Plans, Comprehensive Person-Centered Policy with an updated date of 10/2024, which was provided by the Assistant DON, revealed that a comprehensive, person-centered CP that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . On 2/3/25 at 12:05 PM, the survey team met with the LNHA, DON, and VPoCS for an exit conference, and there was no additional information provided by the facility. 46049 2. On 12/14/23 at 10:14 AM, the surveyor visited Resident #171 in their room. The surveyor observed fewer clothing items by the windowsill, but the resident's bedside remained disorganized and cluttered. On 1/28/25 at 11:02 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #146. A review of the AR revealed that Resident #146 had diagnoses that included, but were not limited to, chronic kidney disease, muscle weakness, bipolar disorder and depression. A review of the comprehensive MDS, with an ARD of 1/13/25, revealed the resident was coded for active diagnoses of bipolar disorder and depression in Section I (Active Diagnoses). The resident was coded for receiving antipsychotic and antidepressant medications under Section N (Medications). A review of the physician's order (PO) dated 1/6/25 indicated Aripiprazole oral tablet 10 milligram (mg) give 1 tablet by mouth one time a day for psychosis. A review of the PO dated 1/6/25 indicated Fluoxetine oral capsule 40 mg give 2 capsules by mouth one time a day for depression. The PO included orders dated 1/6/25 which indicated to monitor the resident for side effects and their behaviors for the psychotropic medications. A review of CP revealed there were no CP related to the resident's psychiatric diagnoses and psychotropic medication use. On 1/28/25 at 11:51 AM, the surveyor interviewed a Registered Nurse (RN) on the unit about CP, and the RN stated the Unit Manager was responsible for reviewing CP. The RN further stated it should be included in a resident's CP if they had psychiatric diagnoses and/or received psychotropic medications. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On that same date and time, the surveyor interviewed the RN/Unit Manager (RN/UM) who stated care planning was a team effort. The RN/UM further stated that the nurses would initiate CP and nurse management staff would review the residents' CP. The RN/UM reviewed with the surveyor the CP of Resident #146 and acknowledged there was no CP related to the resident's psychiatric diagnoses or psychotropic med use. The RN/UM acknowledged that there should be one included in the resident's CP. On 1/28/25 at 1:14 PM, the RN/UM informed the surveyor the CP for Resident #146 was updated to include psychotropic med use and indicated diagnoses. On 1/28/25 at 2:18 PM, the surveyor notified the LNHA, the VPoCS, DON, and the Assistant DON (ADON) of the above concerns. On 1/29/25 at 1:16 PM, the LNHA, the DON, and the VPoCS met with the survey team. The VPoCS stated Resident #146's CP was updated by the RN/UM. A review of the facility's Care Plans, Comprehensive Person-Centered Policy, with a last revised date of October 2024. Under Policy Interpretation and Implementation indicated: 2. The CP interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment . 7. The comprehensive, person-centered CP will: a. Include measurable objectives and timeframes . b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . g. Incorporate identified problem areas . k. Reflect treatment goals, timetables and objectives in measurable outcomes . There was no additional information provided by the facility. NJAC 8:39-11.2 (e), 27.1(a)

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	315295	A. Building B. Wing	02/03/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 38327 Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to adhere to professional standards of clinical practice by failing to a.) ensure the practitioner aware of the situations where other practitioner had potentially misdiagnosed the resident for 1 of 5 residents, Resident #12, reviewed for unnecessary medications (meds) and b.) administer a medication (med) in accordance with the manufacturer's specifications for 1 of 6 residents, Resident #129, reviewed during the med pass observation. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 1/27/25 at 10:59 AM, the surveyor observed Resident #12 seated on the side of the bed and informed the surveyor that they were a short-term resident and had been in and out of the facility for more than three times hospitalization s due to a heart condition. The surveyor reviewed the medical records of Resident #12, and revealed the following: The Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; major depressive disorder (recurrent and mild), cardiac arrhythmia (irregular heartbeat) unspecified, unspecified atrial fibrillation (an irregular and often very rapid heart rhythm), essential hypertension (elevated blood pressure), and type 2 diabetes mellitus without complications. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 11/20/24, under Section C Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 15 of 15, which reflected that the resident had intact cognition. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Psychiatric Follow-up Form (PFF) dated 9/4/24 that was electronically signed by the Advance Practice Nurse (APN#1) reflected that Resident #12's diagnosis included major depressive disorder (recurrent, mild) and schizoaffective disorder, depressive type, and recommended to continue Duloxetine (antidepressant med) HCL (hydrochloride) oral capsule delayed-release sprinkle 30 mg (milligram) daily and increase Seroquel (an antipsychotic med that treats several kinds of mental health conditions including schizophrenia and bipolar disorder) oral tablet (tab) 50 mg BID (twice a day). A review of Resident #12's medical records revealed that there was no documented evidence that the diagnosis of schizoaffective disorder, depressive type was included in the physician services notes, list of diagnosis, PASRR (Preadmission Screening and Resident Review is a federal requirement established to identify individuals with mental illness and/or intellectual developmental disability to ensure appropriate placement in the community or a nursing facility), and other progress notes. On 1/28/25 at 1:58 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON (ADON), and [NAME] President of Clinical Services (VPoCS), and the surveyor notified them of the above findings and concerns. On 1/30/25 at 9:19 AM, the surveyor interviewed APN#2, who informed the surveyor that he was unaware that there was a diagnosis of schizoaffective disorder that was documented for the resident. APN#2 further stated that he would get back to the surveyor. On 2/3/25 at 8:47 AM, APN#2 informed the surveyor that he reviewed all PFFs on file and found out that when the resident came back from hospitalization , APN#1 saw the resident for a follow-up psychiatric consult, increased the med Seroquel, and added the diagnosis of Schizophrenia. APN#2 further stated that in the hospital, when a resident had an order for Seroquel, the hospital put the diagnosis of Schizophrenia, and that was why APN#1 had included the diagnosis in her consultation on 9/4/24. At that same time, APN#2 stated that when he saw the resident for a psychiatric follow-up on 10/10/24 and based on his evaluation and according to the regulation, he GDR (gradual dose reduction) the Seroquel. APN#2 confirmed that the resident had no diagnosis of Schizophrenia. APN#2 further stated that it was clarified in the 1/28/25 PFF that the resident had a history of taking Seroquel but no diagnosis of Schizophrenia Disorder. APN#2 confirmed it was after the surveyor's inquiry that it was clarified that the resident had no Schizophrenia disorder diagnosis. A review of the facility's Antipsychotic Medication Use Policy with an updated date of 10/2024, which was provided by the VPoCS revealed: Policy Statement: Antipsychotic meds may be considered for residents with dementia but only after medical, physical, functional, psychological, emotional psychiatric, social, and environmental causes of behavioral symptoms have been identified and addressed . Policy Interpretation and Implementation: 1. Residents will only receive antipsychotic meds when necessary to treat specific conditions for which they are indicated and effective . 6. Diagnosis of a specific condition for which antipsychotic meds are necessary to treat will be based on a comprehensive assessment of the resident. (continued on next page)

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	02/03/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Antipsychotic meds shall generally be used only for the following conditions/diagnoses as documented in the record, consistent with the definition(s) in the Diagnostic and Statistical Manual of Mental Disorders: a. Schizophrenia; b. Schizoaffective disorder . On 2/03/25 at 12:05 PM, the survey team met with the LNHA, DON, and VPoCS for an exit conference, and there was no additional information provided by the facility. 49078 2. On 1/28/25 at 8:16 AM, the surveyor began the Med Pass Observation task. At 8:17 AM, the surveyor observed the Licensed Practical Nurse (LPN) assigned to Resident #129 prepare and administer meds to the resident. The resident had a total of five meds to be administered, and included Pantoprazole Sodium Oral Tab Delayed Release 40 mg (a medication used to treat stomach ulcers), give 1 tab by mouth BID. While observing the preparation, the surveyor observed the LPN place all the resident's med tablets (tabs) into a plastic envelope used for crushing meds and crushed them all together. The LPN stated that the resident takes their meds crushed over applesauce. The surveyor observed the LPN administer the meds to Resident #129. Upon returning to the med cart, the surveyor asked the LPN how she determined who gets meds crushed, and the LPN stated that it was on the resident's profile. The surveyor observed the resident's profile screen which reflected Takes meds crushed with applesauce. The surveyor asked the LPN if there were any cautionary or warning labels for the Pantoprazole in the computer or on the package. The LPN could not identify any cautions or warning labels to the surveyor. The surveyor reviewed Resident #129's electronic medical record (EMR) which revealed the following. A review of Resident #129's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to gastrointestinal hemorrhage (bleeding in the stomach or intestine) and hyperlipidemia (high levels of cholesterol in the blood). A review of Resident #129's quarterly MDS, with an ARD of 11/7/24, reflected that the resident had a BIMS score of 3 out of 15, which indicated that Resident #129 had severely impaired cognition. A review of Resident #129's Order Summary Report (OSR), a listing of the resident's physician orders (PO), revealed that the resident had a PO for Pantoprazole Sodium Oral Tab Delayed Release 40 mg, give 1 tab by mouth BID for monitoring GI (gastrointestinal) bleed. The above PO for Pantoprazole was transcribed to the January 2025 electronic Medication Administration Record (eMAR) and signed by nurses as administered. A review of the manufacturer's packaging information for Pantoprazole revealed that the packaging information reflected on page #3, Table 2: Administration Instructions. Delayed Release Tabs, swallowed whole . Protonix delayed release tabs should be swallowed whole . A review of the facility's Administering Meds Policy, updated 10/2024, reflected, under #2. Meds must be administered in accordance with the orders . #5. The individual administering the med must check the label . (continued on next page)

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	02/03/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy did not reflect any mention of med administration cautions, warnings, or crushing of meds. On 1/28/25 at 2:07 PM, the survey team met with the LNHA, DON, ADON, and VPoCS to discuss concerns. The surveyor discussed the med pass results and asked the DON and VPoCS if Pantoprazole delayed release tabs should be crushed as per appropriate standards of practice. The DON and VPoCS both replied, no, the Pantoprazole should not be crushed. On 1/29/25, the surveyor reviewed the pharmacy packaging for Resident #129's Pantoprazole. The packaging reflected in small print under the med name, do not crush. The facility did not provide any further pertinent information. NJAC 8:39-11.2(b), 29.2 (d)

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	315295	A. Building B. Wing	02/03/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 38327 Based on observation, interview, record review, and review of pertinent documentation, it was determined that the facility failed to carry out activities per resident's care plan for 1 of 1 resident, Resident #8, reviewed for activities. This deficient practice was evidenced by the following: On 1/27/25 at 10:58 AM, the surveyor observed Resident #8 lying on the bed with eyes closed with the call bell within reach. The surveyor reviewed the medical records of Resident #8, and revealed: A review of the Resident's Admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; essential hypertension (occurs when a resident has abnormally high blood pressure that was not the result of a medical condition), unspecified mood (affective) disorder, and depression unspecified. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with assessment reference date (ARD) 10/31/24, Section C Cognitive Skills with a brief interview for mental status (BIMS) score of 13 out of 15, which reflected that resident's cognition was intact. Further review of the MDS revealed on comprehensive MDS, ARD of 8/8/24, under Section F Preferences for Customary Routine and Activities, resident interview for preferences, the response on how important for the resident to have books, newspapers, and magazines to read was coded 1, which reflected very important. A review of the personalized care plan (CP), focusing on the resident's leisure choices and preferences that was initiated on 2/15/24 had an intervention that included to greet the resident daily with the strolling morning activity cart, offer beverage of choice and reading material for self-direction that were initiated on 2/15/24. A review of the Recreation Comprehensive Assessment, with an effective date of 8/6/24, reflected that Resident #8 accepted a beverage of choice and the paper subscription [name redacted] (publication used in senior living environments; that included trivia, historical facts, and thought-provoking material, such as quotes of the day, historical happenings, and famous birthdays) reading materials. On 1/28/25 at 11:14 AM, the surveyor observed the resident lying in bed asleep. The surveyor did not observe reading materials from today and yesterday's (1/27/25) tour. On 1/29/25 at 10:39 AM, the surveyor observed the Activities Aide Recreation (AAR) with a cart in the hallway near the resident's room. The surveyor interviewed the AAR, who informed the surveyor that she knew Resident #8 and the resident's preferences. She acknowledged that the preference of the resident should be in the CP in order to respect their wishes and to notify other staff who cared for the resident. She further stated that the resident liked to read and that included subscription reading material that was identified in the resident's CP and assessment. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On that same date and time, the surveyor notified the AAR of the above findings and concerns that for two days of observations, there were no reading materials inside the resident's room. The AAR stated that she was aware that there was no subscription reading material in the resident's room from November, December 2025, and this month (January 2025) because their new Activity Director had no access to the subscription reading material. On 1/29/25 at 1:16 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and [NAME] President of Clinical Services (VPoCS), and the surveyor discussed the above findings and concerns. A review of the facility's Activity Policy, with a reviewed date of 10/2024, that was provided by the DON reflected that the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, CP, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being . On 2/03/25 at 12:05 PM, the survey team met with the LNHA, DON, and VPoCS for an exit conference, and there was no additional information provided by the facility. NJAC 8:39-4.1 (a)(24); 7.1(a); 8.1

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	02/03/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 38327 Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, by failing to; a.) follow the physician's order (PO) for laboratory and daily weight, b.) ensure congestive heart failure assessment was accurately done according to the PO, and c.) follow through the recommendations of the cardiologist. This deficient practice was identified for 1 of 32 residents, Resident #12, and was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the state of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling and provision of care supportive to or restorative of life and well-being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. On 1/27/25 at 10:59 AM, the surveyor observed Resident #12 seated on the side of the bed and informed the surveyor that they were a short-term resident and had been in and out of the facility more than three times hospitalization s due to a heart condition. The surveyor reviewed the medical records of Resident #12, and revealed the following: The Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; major depressive disorder (recurrent and mild), cardiac arrhythmia (irregular heartbeat) unspecified, unspecified atrial fibrillation (an irregular and often very rapid heart rhythm), essential hypertension (elevated blood pressure), and type 2 diabetes mellitus without complications. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 11/20/24, under Section C Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 15 of 15, which reflected that the resident had intact cognition. A review of Resident #12's active PO revealed the following: Ordered date 9/19/24 for daily weights before breakfast one time a day. Ordered date 9/19/24 CHF assessment and documentation every shift. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ordered date 10/14/24 CMP (comprehensive metabolic panel is a blood test that measures proteins, enzymes, electrolytes, minerals, and other substances in the body) to be done on 10/18/24. Ordered date 11/7/24 CBC with diff (complete blood count with differential is a blood test that measures amounts and sizes of red blood cells, hemoglobin, white blood cells, and platelets), CMP, BNP (Brain Natriuretic Peptide test is a blood test that measures levels of a protein called BNP, produced by the heart and blood vessels. It's primarily used to diagnose and assess the severity of heart failure), and Mag (magnesium, a test called a serum magnesium test measures the amount of magnesium in the bloodstream) weekly every Monday. Further review of the medical records revealed: The above PO for daily weight was transcribed in the January 2025 electronic Treatment Administration Record (eTAR), and there were no weights documented for dates; 1/1, 1/2, 1/3, 1/5, 1/7, 1/8, 1/9, 1/11, 1/12, 1/13, 1/15, 1/18, and 1/19/25. A review of the Progress Notes (PN) revealed that 10 out of 13 times the physician was not notified of the weight refusal nor why weight were not done. The above PO for CHF assessment and documentation was transcribed in the January 2025 eTAR, and there were no consistencies in the documentation and the order was not followed. A review of the provided copies of laboratory (lab) results revealed that there was no documented evidence that the order for CMP to be done on 10/18/24 was done. Further review of the laboratory results revealed that the order for every Monday CBC with diff, CMP, BNP, and Magnesium were not followed, as evidenced by the following: There was no lab done for dates 12/16/24, 12/23/24, 12/30/24, 1/6/25, 1/13/25, 1/20/25, and 1/27/25 There was no lab done for Magnesium for dates 11/11/24, 11/18/24, 11/25/24, 12/2/24, 12/9/24, and 1/3/25. There was no documented evidence the physician was notified of the lab orders that were not done and why it was not done. On 1/28/25 at 11:28 AM, the surveyor interviewed the Registered Nurse (RN) in the presence of the RN/Unit Manager (RN/UM), and the Infection Preventionist Nurse (IPN). The RN informed the surveyor that the resident was being followed up by a Cardiologist due to cardiac problems and CHF. The surveyor asked the RN if the resident was being weighed or had an order for a weight schedule, and the RN stated that she was unsure, maybe once a week. The IPN stated that for CHF the resident was to be weighed every day. The surveyor asked the RN about the resident, and the RN/UM was the one who responded that Resident #12 was cognitively intact, independent with care most part, and cueing at times due to psychiatric diagnosis. (continued on next page)

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	02/03/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On that same date and time, the surveyor notified the RN and the RN/UM of the above findings and concerns about CHF assessment and documentation every shift, daily weights, and lab routine as ordered that were not followed, and the surveyor asked what happened. The RN did not respond. The RN/UM stated as the standard of practice, the orders should have been followed, if the resident refused, it should be documented and notified the physician of refusals. At that time, the surveyor asked about the resident's follow-up consults, and the RN/UM showed the most recent Cardiology follow-up on 1/14/25 with recommendations. The recommendation was a Psychiatry evaluation as the resident was refusing life-saving procedures repeatedly and to start Mexiletine (a medication used to treat abnormal heart rhythms, chronic pain, and some causes of muscle stiffness) 150 mg (milligram) three times a day. The surveyor asked the RN/UM if the recommendations were followed through and if it was documented, and the RN/UM stated that the Psychiatric doctor comes in once a week and sees residents in the unit. The RN/UM was not able to provide evidence that the recommendation for Psychiatric evaluation was followed. The RN/UM had no response when asked by the surveyor why the resident was not on the list of residents to be seen by the Psychiatrist. A review of the provided list of residents that were seen by the Psychiatrist revealed that on 1/16/25 and 1/17/25, the resident was not on the list. Furthermore, the RN/UM confirmed the above dates that the lab report did not include Magnesium and the dates that lab should have been done and were not done. The RN/UM was unable to provide documentation that the physician was notified of the above concerns and why the lab order, CHF assessment, and documentation were not followed according to the PO. On 1/28/25 at 1:58 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON (ADON), and [NAME] President of Clinical Services (VPoCS), and the surveyor notified them of the above findings and concerns. A review of the facility's Physician Orders Policy with an updated date of 3/2024, which was provided by the VPoCS revealed under Policy: Medication and treatment orders will be accepted only from authorized, credentialed physicians or from other authorized, credentialed practitioners in accordance with state regulations regarding prescriptive privileges . A review of the facility's Laboratory and Reporting Policy with a reviewed date of 5/2024, which was provided by the VPoCS revealed: Policy: the facility must provide or obtain lab services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. Policy Explanation and Compliance Guidelines: 1. The facility must provide or obtain lab services to meet the needs of its residents. 2.The facility is responsible for the timeliness of the services . On 2/3/25 at 12:05 PM, the survey team met with the LNHA, DON, and VPoCS for an exit conference, and there was no additional information provided by the facility. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NJAC 8:39-3.2(a,b); 11.2(b);27.1(a)

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	315295	A. Building B. Wing	02/03/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 46049 Based on observation, interview, and record review, it was determined that the facility failed to clarify physician's orders to ensure appropriate care and services for a resident receiving enteral feedings. This deficient practice was identified for 2 of 3 residents (Residents #7 and #94), reviewed for enteral (tube) feeding. This deficient practice was evidenced by the following: 1. On 1/27/25 at 10:19 AM, the surveyor observed Resident #7 lying in their bed with the head of bed elevated and the resident's representative (RR) was visiting at the bedside. The resident was alert and verbally responsive to simple questions. Resident #7 had tube feeding supplies at the bedside. The RR stated that the resident receiving enteral feedings and was also on a diet to receive PO (by mouth) foods. The RR stated that the intake via enteral feeding had decreases as the resident's PO intake increased. The RR had no concerns with the resident's enteral feeding care or nutrition. On 1/28/25 at 12:24 PM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #7. A review of the Admission Record (AR; a summary of important information about the resident) documented the resident had diagnoses that included but were not limited to, dementia, muscle weakness, dysphagia (difficulty swallowing), atrial fibrillation (an irregular heart rhythm), and gastrostomy (surgical opening in the abdominal wall and into the stomach). A review of the quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 10/25/24, a Brief Interview Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. In Section K (Swallowing/Nutritional Status), Resident #7 was coded as receiving nutrition through a feeding tube as well as a mechanically altered diet. Additionally, it was coded that the resident received 26 to 50 % of their total calories through their feeding tube. A review of the January 2025 electronic Medication Administration Record (eMAR) and physician's orders (PO) revealed the following: A PO dated 9/10/24, indicated to provide water flush of 200 milliliter (ml) every shift for hydration. The entry was scheduled for each shift and the nurses signed and recorded TV (total volume) of 200 ml being administered. A PO dated 9/19/24 revealed enteral feed order every day shift [7:00 AM to 3:00 PM shift] for nutrition; Jevity 1.5 continuous at 60 milliter/hour (ml/hr) for 8 hours or until the TV of 480 ml was infused. Record TV infused in the eMAR. The entry was scheduled on the eMAR for 7-3 shift and the nurses signed and documented the TV. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A PO dated 9/19/24 revealed enteral feed order every shift for nutrition; Jevity 1.5 continuous at 60 ml/hr for 8 hours or until the TV of 480 ml was infused. Record TV infused in the eMAR. The entry was scheduled for each shift and the nurses signed and recorded TV of 200 ml being administered. A PO dated 9/19/24 revealed enteral feed order one time a day for nutrition; Jevity 1.5 continuous at 60 ml/hr for 8 hours or until the TV of 480 ml was infused. Record TV infused in the eMAR. The entry was scheduled on the MAR for 9:00 PM and the signed and documented the TV. A PO dated 9/19/24 revealed enteral feed order every shift for hydration; Water flush of 200 ml every shift providing a 600 ml TV of water flush. The entry was scheduled for each shift and the nurses signed and recorded TV of 200 ml being administered. On 1/28/25 at 1:02 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN#1) who was assigned to care for Resident #7 who stated the resident had a regular diet and received tube feeding in the evening for a total of 8 hours. LPN#1 explained the resident did not receive feeding on the day shift and received their enteral feeding on the evening and night shift. Additionally, the LPN stated the resident received 200 ml water flush every shift. The surveyor reviewed with LPN#1, the enteral feeding entries on the eMAR. For the three entries concerning Jevity 1.5, LPN#1 explained that the one entry at 9:00 PM was for when the feeding was started, that every shift documented the TV the resident had received and that the resident gets the feeding only for the 8 hours. The surveyor asked the about the two water flush entries. LPN#1 replied that the resident gets only 600 ml every day, 200 ml per shift. LPN#1 stated the other entry was a duplicate order and the nurses knew that the resident received 200 ml every shift and not 400 ml every shift. LPN#1 added that the nurses would know that it was a duplicate order. The surveyor asked LPN#1, if nurses were aware it was a duplicate order, what would be expected. LPN#1 acknowledged that it would be expected for the order to be clarified. On 1/28/25 at 1:08 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) who stated tube feeding order entries should indicate the type of feeding, the rate, the duration (the hours or the TV to be infused), and the start time of the feeding. The surveyor notified the RN/UM of the concerns found with the order entries for Resident #7 and the discussion with LPN#1. The RN/UM stated Resident #7 received their enteral feeding at 9:00 PM and the order entry scheduled for 9:00 PM indicated the feedings' start time. The RN/UM acknowledged all three entries had similar orders and the nurses were to check the TV every shift to ensure that the resident received their 8 hours feeding. The RN/UM further explained it was part of the facility's protocol and that was why there was an order indicating every shift for enteral feedings. The RN/UM stated for the two water flush orders, it should have been clarified by the nurses as it was a duplicate order to prevent errors. The RN/UM stated she would follow up to have the order clarified with the RD and the physician. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 2:18 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), the Assistant Director of Nursing (ADON), and the [NAME] President of Clinical Services (VPoCS) of the above concerns regarding the enteral feeding and water flush orders for Resident #7. On 1/29/25 at 1:17 PM, the LNHA, the VPoCS, and the DON met with the survey team. The VPoCS stated the resident's orders were reviewed, and re-formatted so that the enteral feeding orders were clear. The water flushed were clarified, the resident was to receive 200 ml every shift and one order was discontinued. A review of the facility's Enteral Tube Feeding via Continuous Pump Policy, with a last reviewed date of October 2024. Under Preparation, the policy indicated to verify the PO for the procedure of enteral tube feeding. Under Documentation revealed information that should be recorded in the resident's medical record which included the date and time the procedure was performed and the average fluid intake per day. The policy did not further address documentation in the MAR or the protocol for enteral feeding orders. There was no additional information provided by the facility. 39885 2. On 1/27/25 at 10:14 AM, the surveyor observed Resident #94 lying in bed with the head of the bed elevated. The surveyor observed on the bedside table a piston syringe (used for a gtube) filled with clear liquid. The surveyor observed that there was no date written on the piston syringe or the plastic bag that it had come in. The surveyor then observed on the bedside dresser a suction machine. The suction canister which had secretions in it was dated 1/7/25. The surveyor observed that there was suction tubing and a yankauer tip attached to the suction canister. The yankauer tip was laid on the bedside dresser. The yankauer tip was not stored in a plastic bag. On 1/28/25 at 9:31 AM, the surveyor interviewed LPN#2, who stated that the piston syringe was changed every day and was dated by the night shift. LPN#2 stated that the suction machine canister was changed daily and the yankauer was replaced with a new one after each use. LPN#2 confirmed that the piston syringe should have been dated and the yankauer tip should have been discarded. On 1/28/25 at 10:05 AM, the surveyor interviewed the second floor Unit Manager (UM). The second floor UM stated that every 11-7 shift changed the piston syringe and that it should be dated. The UM stated that the suction canister was changed one time a week and that the yankauer tip should be thrown away after each use. A review of Resident #94's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; aphasia following cerebral infarction, dysphagia (difficulty swallowing foods or liquids) and gastrostomy status (surgical procedure that creates an opening in the stomach through the abdominal wall to insert a tube used for feeding). A review of Resident #94's quarterly MDS reflected that the resident's cognitive skills for daily decision making was severely impaired. Further review indicated that Resident #94 had a feeding tube and received 51% or more of total calories and 501 cc/day or more through the tube feeding. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident # 94's January 2025 eMAR and PO revealed the following orders: A PO dated 12/24/24 for enteral feed order every day shift [7 AM to 3 PM shift] for nutrition; Glucerna 1.5 to 60 ml/hr x (times) 18 hrs or until TV of 1170 ml was infused. The entry was scheduled on the eMAR for Day 7 (7-3 shift) and the nurses signed and documented the TV as 1170 or 455 each day of the month. An additional PO dated 12/24/24 revealed enteral feed order one time a day for nutrition; Glucerna 1.5 to 65 ml/hr x 18 hrs or until the TV of 1170 ml was infused. The entry was scheduled on the eMAR for 1600 (4 PM) and the nurses signed and recorded TV of 420, 455 or 1170 ml being administered. There were two orders for the same enteral feed and each had a different rate of infusion. Further review revealed a PO dated 12/26/24 for enteral feed order everyday shift for hydration auto water flush at 40 ml/hr x 18 hrs or until TV of 720 ml free water is infused. The entry was scheduled on the eMAR for Day 7 (7-3 shift) and the nurses signed and documented the TV as 240, 320, 720 or 1170 each day of the month. An additional PO dated 12/26/24 for enteral feed order one time a day for hydration auto water flush at 40 ml/hr x 18 hrs or until TV of 720 ml free water is infused. The entry was scheduled on the eMAR for 1600 and the nurses signed and documented the TV as 240, 280 or 720 ml free water was infused. There were two orders for the same free water infusion. On 1/28/25 at 2:35 PM, the surveyor notified the LNHA, DON, Assistant DON (ADON) and the VPoCS the concerns that Resident #94's piston syringe was not dated, the yankear tip was not stored in a plastic bag or thrown away and that the resident had duplicate enteral feed and free water orders. On 1/29/25 at 1:28 PM, in the presence of the LNHA and DON, the VPoCS stated that the staff were inserviced on the piston syringe and suction equipment. The VPoCS then stated that they reformatted the enteral feed orders so they were not confusing and not duplicated. A review of the facility's Enteral Tube Feeding via Continuous Pump Policy, with a revised date of 10/2024, included the following under Equipment and Supplies: 6. Sixty (60) ml enteral syringe (with transition adapter if necessary); . There was no additional information about the storage or dating of the syringe. A review of the facility's Suction Policy, with a revised date of August 2014, included the following: 12. When suction equipment is designated for a particular resident for extended use, suction connecting tubing and suction collecting canister need not be discarded on a regular schedule, but should be cleaned and flushed as necessary when secretions are present. If the suction connecting tubing becomes visibly soiled with secretions that will not flush, new tubing may be attached. The suction collection canister should be emptied and cleaned daily and changed or decontaminated as necessary. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	13.Discard disposable suction collecting canisters. The policy did not address the yankauer tip usage or storage. The facility did not provide any additional information. N.J.A.C. 8:39-25.2(c)2; 27.1 (a)

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	315295	A. Building B. Wing	02/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 38327 Based on observations, interviews, record review, and other pertinent facility documentation, it was determined that the facility failed to ensure the necessary respiratory care and services of residents receiving oxygen according to the standard of clinical practice and the facility's policy and procedure. This deficient practice was identified for 3 of 3 residents, Residents #23, #88, and #142, reviewed for respiratory care, and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 1/27/25 at 10:59 AM, the surveyor observed Resident # 23 lying on the bed with BIPAP (Bilevel positive airway pressure, is a machine that helps resident breathe and a form of noninvasive ventilation) and nebulizer (neb) machine on top of the nightstand table. On 1/28/25 at 11:16 AM, the surveyor observed the resident lying on the bed. The resident informed the surveyor that they use the oxygen (O2) as needed (PRN) and the BIPAP at night. On 1/28/25 at 11:21 AM, both the surveyor and Registered Nurse #1 (RN#1) went inside the resident's room and observed a tape in the nebulizer tubing dated 1/24/25. The surveyor asked RN#1 to check the BIPAP mask, the RN took the BIPAP mask inside the nightstand drawer that was stored inside a plastic bag with no date. On that same date and time, the resident informed RN#1 that their BIPAP mask should have been replaced last November 2024 and someone had promised the resident and did not get back to them. RN#1 stated that she was unaware of who was the person who promised the resident a new BIPAP mask, and notified the resident that she would check. Outside the resident's room, the surveyor asked RN#1 what the facility's practice and policy about the care of BIPAP masks was. RN#1 informed the surveyor that she was unsure on how often the BIPAP mask should be changed, she knew that for the neb mask, it should be changed by 11-7 shift nurse I think weekly. The surveyor also asked the RN if there was an accountability on how to care for the BIPAP mask, and she said she was unsure. The surveyor reviewed the medical records of Resident #23 and revealed: (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Admission Record (AR, an admission summary) revealed that the resident was admitted to the facility with diagnoses that included but were not limited to sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts) and chronic obstructive pulmonary disease (COPD, is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough) unspecified. A review of the most recent quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 12/6/24, Section C Cognitive Patterns a brief interview for mental status (BIMS) score of 15 out of 15, which reflected that the resident's cognition was intact. A review of the Order Summary Report (OSR) revealed a Physician Order (PO) dated 7/18/24, to apply BIPAP settings: 18/6 FIO2 (fraction of inspired oxygen (FiO2) is the concentration of O2 in the gas mixture) 30%, frequency: on at HS (hours of sleep, also known as bedtime) and off in the AM (morning) for hypercapnia (a condition that occurs when a person has too much carbon dioxide in their bloodstream) and remove per schedule. The above order for BIPAP was transcribed to the electronic Treatment Administration Record (eTAR) and signed by nurses as administered, at 9:00 PM and removed at 8:00 AM for September, October, November, December 2024, and January 2025. A review of the personalized Care Plan (CP) revealed that no plan of care addresses the BIPAP mask care and accountability. Further review of the medical records revealed that there was no evidence on when and how to care for BIPAP mask. On 1/28/25 at 1:58 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON (ADON), and [NAME] President of Clinical Services (VPoCS), and the surveyor notified the of the above findings and concerns. On 1/29/25 at 1:16 PM, the survey team met with the LNHA, DON, and VPoCS. The surveyor asked the VPoCS what the facility's practice, protocol, and policy about the care of BIPAP masks, and the VPoCS responded that they should have the BIPAP mask replaced every three months, and as needed, and that was our policy. The surveyor asked how the nurse knows when to change it and should be accountable. The VPoCS stated that moving forward we put an order on when to replace it as part of accountability that was to change every three months, according to our policy. On 2/3/25 at 12:05 PM, the survey team met with the LNHA, DON, and VPoCS for an exit conference, and there was no additional information provided by the facility. 39885 2. On 01/27/25 at 10:17 AM, the surveyor entered Resident #142's room. The surveyor observed that there was a nasal cannula (NC) O2 tubing that was connected to an O2 concentrator and the NA part of the tubing was laid on the resident's bed. The NC tubing was not stored in a plastic bag while not in use. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/25 at 10:25 AM, the surveyor observed Resident #142 seated in a wheelchair (wc) in the unit's dayroom and was receiving O2 at 2 lpm (liters per minute) via a NC O2 tubing that was attached to a portable O2 tank attached to the back of the wc. On 1/28/25 at 9:40 AM, the surveyor observed Resident #142 laying in bed and was receiving O2 at 2 lpm via a NC O2 tubing which was connected to an O2 concentrator. The surveyor observed an additional NC O2 tubing that was connected to a portable O2 tank that was on the resident's wc. The surveyor observed that the NC part of the tubing was laid on the wc seat. The NC tubing was not stored in a plastic bag while not in use. On 1/28/25 at 9:40 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding the process for O2 via NC. The LPN stated that the resident had one NC O2 tubing for the concentrator and another NC O2 tubing for the portable tank and that the tubings should be in a plastic bag when not in use. The surveyor then showed the LPN the tubing that was laid on Resident #142's wc and he confirmed that the tubing should not be stored that way. On 1/28/25 at 9:44 AM, the surveyor interviewed the second floor Unit Manager (UM) regarding the storing of NC O2 tubing. The second floor UM stated that the NC should be stored in a plastic bag. The surveyor then showed the second floor UM the tubing that was laid on Resident #142's wc and he confirmed that the tubing should be in a plastic bag. He added that the resident transferred themselves. A review of Resident #142's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to congestive heart failure (a chronic condition where the heart muscle weakens and cannot pump blood effectively) and idiopathic pulmonary fibrosis (idiopathic pulmonary fibrosis). A review of Resident #142's most recent quarterly MDS, reflected that the resident had a BIMS score of 15 out of 15, which indicated that Resident #142 was cognitively intact. On 1/28/25 at 2:00 PM, the surveyor notified the LNHA, DON, Assistant DON (ADON) and VPoCS the concern that Resident #142's O2 tubing was not stored properly. On 1/29/25 at 1:28 PM, in the presence of the LNHA and DON, the VPoCS stated that the staff were inserviced on the O2 tubing. A review of the facility's Oxygen Therapy Policy, with a reviewed date of 8/2024, included the following: 5. Staff shall perform hand hygiene and don (put) gloves when administering O2 or when in contact with O2 equipment. Other infection control measures include: . b. Change O2 tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated . e. Keep delivery devices covered in plastic bag when not in use . The facility did not provide any additional information. (continued on next page)

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	02/03/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46049 3. On 1/27/25 at 10:02 AM, the surveyor observed Resident #88 lying in bed with their head of bed elevated. The resident opened their eyes spontaneously upon the surveyor's verbal greeting and the resident was non-verbal. Resident #88 had a tracheostomy collar over the tracheostomy. The tracheostomy collar delivered O2 to the resident via the tracheostomy. The resident had supplies, including for their trach at the bedside. There were no observed concerns. On 1/29/25 at 11:05 AM, the surveyor interviewed RN#2 assigned to care for Resident #88. RN#2 stated the resident received trach care every shift and PRN. RN#2 further explained the trach mask and tubing were changed weekly, the trach inner cannula was changed on 11-7 shift and PRN. RN#2 stated the resident used inner cannula size #8. The surveyor accompanied the surveyor to the resident's and showed the resident's trach supplies that were available at the bedside. On 1/30/25 at 9:10 AM, the surveyor reviewed the paper chart and electronic medical record (EMR) of Resident #88. A review of the AR reflected that Resident #88 had diagnoses that included but were not limited to, epilepsy (a seizure disorder), chronic respiratory failure, tracheostomy, and traumatic brain injury. A review of the quarterly MDS, with an ARD of 1/10/25, was coded as rarely/never understood. In Section O (Special Treatments, Procedures, and Programs) of the MDS it was coded that the resident received trach care and O2 therapy. A review of the following PO revealed: A PO dated 1/3/25, indicated to trach care daily every shift. A PO dated 1/3/25, indicated to trach care daily PRN. A PO dated 1/3/25, indicated to assess skin around stoma site and under ties every shift. A PO dated 1/3/25, indicated to change trach ties once a week every Thursday every night shift. A PO dated 1/3/25, indicated to change trach collar large volume administration set and tubing every Thursday on night shift. A PO dated 1/28/25, indicated O2 at 8lpm via trach collar mask every shift. There was no PO indicating inner cannula trach change and no indication of the inner cannula size for the resident. On 1/30/25 at 9:27 AM, the surveyor interviewed the RN/Unit Manager (RN/UM) about trach care who stated there was an order set for trach care. The RN/UM further stated a trach inner cannula should be changed daily and PRN. The RN/UM explained for an inner cannula change there would be an individual PO entry to indicate when it was to be completed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RN/UM reviewed with the surveyor Resident #88's electronic Medication Administration Record (eMAR) and confirmed there was no order which indicated the frequency of the trach inner cannula change and the inner cannula size. The RN/UM stated a respiratory care vendor evaluated the resident monthly and as needed, in which their assessment would include cannula size and any additional recommendations. On 1/30/25 at 9:51 AM, the surveyor interviewed the DON about trach care protocol, including trach inner cannula change. The DON stated he would get back to the surveyor with additional information. On 1/30/25 at 10:59 AM, the DON stated that inner cannula change was part of trach care order, and the facility collaborated with the respiratory vendor for recommendations. The DON further explained the respiratory vendor assessment included inner cannula trach size the resident should be using, which was size #8. The surveyor reviewed with the DON the January 2025 eTAR which revealed trach care was done every shift and resident had a previous order for inner cannula change on 11-7 shift dated 8/31/24 and discontinued on 1/2/25. The surveyor asked if inner cannula change was being done every shift or once daily as the nurses stated inner cannula change was done daily on 11-7 shift. The DON stated that he would review and provide additional information. On 1/30/25 at 11:11 AM, the DON stated that inner cannula change should be done daily and trach care every shift. The DON stated he clarified with respiratory vendor for recommendations. The DON acknowledged there should have been a PO to indicate frequency of inner cannula change and an order was entered. The previous order that was discontinued on 1/2/25 was due to resident being sent out of the facility and when the resident returned the order was not resumed. On 1/30/25 at 2:16 PM, the surveyor informed the DON and the VPoCS of the concern regarding there being no PO to indicate trach inner cannula change. On 2/3/25 at 10:32 AM, the LNHA, the DON, and the VPoCS met with the survey team. The DON stated the trach POs for the resident were reviewed and updated and education was provided to the nursing staff. A review of the facility's Tracheostomy Care Policy, with a last reviewed date of October 2024. Under General Guidelines revealed: 5. Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies . The policy included the procedure of cleaning a trach inner cannula. The policy did not further address inner cannula change. There was no additional information provided by the facility. NJAC 8:39-11.2(a)(b); 19.4(a); 27.1(a)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 39885 Complaint NJ #176546 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to: a.) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey and b.) answer call bells and provide incontinence care in a timely manner. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes, indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 1. On 1/27/25 at 9:30 AM, the surveyor interviewed the second floor Unit Manager (UM) regarding the unit's resident census and staffing. The second floor UM stated that the resident census was 55 and that there were 5 CNAs. The calculated ratio was 1 CNA for 11 residents. On 1/27/25 at 12:09 PM, the surveyor interviewed CNA #1 regarding her assignment. CNA #1 stated that she was assigned that day to care for 11 residents. The surveyor asked CNA #1 if that was the usual amount of residents that she had on her assignment. CNA #1 stated that it depended on how many CNAs were assigned to the unit. She added that if the unit had 6 CNAs then her assignment would have 9 residents to care for. On 1/27/25 at 10:04 AM, the surveyor interviewed Resident #93 regarding staffing and call bell response time. Resident #93 stated that sometimes it took the staff one or two hours to answer the call bell. Resident #93 stated that their device that they used to hold urine would be full and would not be able to use it. A review of Resident #93's Admission Record face sheet (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; blindness one eye, hypertension and type 2 diabetes mellitus. A review of Resident #93's most recent quarterly Minimum Data Set (MDS), an assessment tool, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that Resident #93 was cognitively intact. Further review indicated that Resident #93 needed partial moderate assistance with transfer and toileting. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #93's care plan (CP) included the following intervention: Provide frequent visits to anticipate needs in toileting, offer and provide urinals and explain location, emphasize the importance of calling and waiting for assistance. 2. On 1/27/25 at 10:53 AM, the surveyor interviewed Resident #89 regarding staffing and call bell response time. Resident #89 stated that the day before they had to wait longer than usual to get back in bed and that their incontinence brief was soaked with urine. Resident #89 stated that they asked the nurse to put them back to bed to be changed but that the nurse stated she would have one of the aids do it. Resident #89 stated that usually when their aid came in at 3:00 PM and would put them in bed by 3:30 PM but that yesterday it was a different aid and they were not put back in the bed until 4:45 PM. A review of Resident #89's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; spinal stenosis, heart failure and hypothyroidism. A review of Resident #89's most recent quarterly MDS, reflected that the resident had a BIMS score of 15 out of 15, which indicated that Resident #89 was cognitively intact. Further review indicated that Resident #89 was dependent with transfer and toileting. A review of Resident #89's CP included the following intervention: Encourage to use bell to call for assistance. On 1/28/25 at 2:03 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assistant DON (ADON) and [NAME] President of Clinical Services (VPoCS) the concern that Resident #89 and #93 complained that they had to wait a long time for their call bell to be answered and that the second floor unit on 1/27/25 had only 5 CNAs for a census of 55 residents which was below the 1 CNA to 8 resident mandated ratio. On 1/29/25 at 11:06 AM, the surveyor interviewed the Staffing Coordinator (SC) regarding staffing ratios. The SC confirmed that she knew the required ratios. She stated that she meets the ratios but that at times there are callouts and she would try to replace them. The SC stated that currently they were not using agency staff. The surveyor asked how the SC staffed the facility. The SC stated that she staffed for each unit. She added that for the second floor unit it depended on the census. The SC stated that sometimes she staffed 6 CNAs and sometimes 5 CNAs depending on the census. The surveyor asked the SC about 1/27/25. The SC stated that on that day there was a callout and that the person she replaced for the callout also called out. On 1/29/25 at 1:28 PM, in the presence of the LNHA and DON, the VPoCS stated that the staff were inserviced on call bell response and that there were call outs and they tried to replace the staff. A review of the facility's Staffing Policy, with a revised date of October 2024, included the following: 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care or applicable federal/state laws A review of the facility's Call Lights Policy, with an updated date of 1/2025, included the following: Purpose: To use a light and/or sound system to alert staff to patient needs. Procedure: 1. Answer all call lights in a prompt, calm, courteous manner. All staff, regardless of assignment must answer call lights . 5. Respond to request or, if unable to do so, refer request to appropriate staff member immediately . The facility did not provide any additional information. N.J.A.C. 8:39-27.1 (a) 46049

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	315295	A. Building B. Wing	02/03/2025

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurse aides who have worked more than 4 months, are trained and competent; and nurse aides who have worked less than 4 months are enrolled in appropriate training. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885 Complaint # 168864 Based on interview and review of pertinent facility documents, it was determined that the facility failed to ensure and have documented evidence a.) that Temporary Nurse Aides (TNAs) were enrolled in school prior to 5/11/23 and completed their Certified Nurse Aide (CNA) certification by 9/11/23 as mandated by Centers for Medicare and Medicaid Services (CMS) and New Jersey Department of Health (NJDOH) in order to continue to work after 5/11/23; b.) of verification that the non-certified NAs were currently enrolled and actively taking classes in a New Jersey state-approved Certified Nursing Aide (CNA) Training Program and validate completion of Module 1 in their CNA Training Program prior to allocating an independent resident assignment, 2 of 2 non-certified NAs that were previously working as TNAs; and c.) there was a delineated policy and/or program in place for the hiring, staffing, and assignments of non-certified NAs. This deficient practice was evidenced by the following: Reference: CMS Center for Clinical Standards and Quality/Quality, Safety& Oversight Group (QSO) Memorandum (memo) QSO-21-17-NH, with an updated date of 5/10/2021 included the following regarding TNAs: Additionally, CMS waived the requirements that prohibit a nursing home from using any individual working in the facility as a nurse aide for more than four months unless they complete certain requirements (per 42 CFR S483.35(d)(1)). While this waiver has been in effect, many nurse aides have been able to work longer than four months to support facilities' staffing needs. However, nursing homes and nurse aides have raised concerns about what will happen when the waiver ends. For example, CMS has received questions on whether these individuals will need to leave the nursing home immediately when the waiver ends, if they have not completed the requirements for certification in the last four months. Though this waiver is not being terminated at this time, we are advising stakeholders that the four-month regulatory timeframe will be reinstated when the blanket waiver ends and will start at that time. In other words, nurse aides will have the full four month period starting from the end of the blanket waiver to successfully complete the required training and certification, regardless of the amount of time worked during the time the waiver was in effect. However, though nurse aides will have up to four months from the end of the blanket waiver to complete the required training and certification, we strongly encourage states and nurse aides to explore ways to complete all the training and certification requirements as soon as possible. Reference: CMS QSO memo QSO-22-15-NH & NLTC & LSC, with an updated date of 8/29/2022 included the following regarding TNAs: CMS waived the requirements which require that a SNF (Skilled Nursing Facility) and NF (Nursing Facility) may not employ anyone for longer than four months unless they met the training and certification requirements under S483.35(d). CMS previously provided information related to nurse aides working under this blanket waiver in CMS memorandum QSO-21-17-NH. This memo provides additional information as well on the modification of this waiver below. (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	We remind states that all nurse aides, including those hired under the above blanket waiver at 42 CFR S483. 35(d), must complete a state approved Nurse Aide Competency Evaluation Program (NATCEP) to become a certified nurse aide. State approved NATCEPs must have a curriculum that includes training in the areas defined at 42 CFR S483.152(b), such as respecting residents' rights, basic nursing skills, personal care skills, and caring of cognitively impaired residents. Additionally, the requirements at 42 CFR S483.154(b)(i) and (ii) requires these nurse aides pass a written or oral exam, and demonstrate skills learned. Lastly, we note that CMS did not waive the requirement that the individual employed as a nurse aide be competent to provide nursing and nursing related services at 42 CFR S483.35(d)(1)(i), and that requirement must continue to be met. Reference: State of New Jersey Department of Health memo dated April 21, 2023 sent to Nursing Homes included the following: On February 27, 2023, the CMS announced that all nurse aide emergency training waivers will terminate at the end of the Federal Public Health Emergency (PHE). The PHE is expected to end on May 11, 2023. At that time, all TNAs hired prior to the end of the PHE and who have enrolled in a NATCEP program and completed the first 16 hours of training prior to May 11, 2023, must complete the NATCEP and pass the nurse aide written exam and the clinical skills competency exam by September 10, 2023. Nurse aides hired after the end of the PHE will have four months to complete a NATCEP program and pass the exams, as required by N.J.A.C. 8:39-43.1. The New Jersey Department of Health issues this memorandum to update facilities on the interpretation of the CMS guidance, P.L. 2021, c. 326, c. 368 and Executive Directive (ED) 20-004 (Revised July 6, 2022). Facilities are advised as follows: I. TNAs A. Individuals who are working as TNAs must pass the nurse-aide written or oral exam and the State-approved clinical skills competency exam by May 11, 2023, or the end of the federal PHE, whichever comes first. B. If a TNA does not pass the exams by the end of the federal PHE, the TNA may not work after May 11, 2023, unless the TNA meets the requirements of Paragraph C below. C. In order to work beyond May 11, 2023, TNAs must, by May 11, 2023: 1. Be enrolled in a NATCEP CNA training program, and 2. Have completed the first 16 hours of training, and 3. Be working in a facility before May 11, 2023. 4. Note that the TNA only has until September 10, 2023 to complete the NATCEP program and pass the exams. II. Nurse Aides (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Aides (not TNAs) who are enrolled in a NATCEP program must finish training and pass the nurse-aide written or oral exam and the State approved clinical skills competency exam within the usual 120 days, pursuant to N.J.A.C. 8:39-43.1. After completing the first 16 hours of training, the nurse aide may work in a nursing home while completing the training and testing. On 1/27/25 at 9:47 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and [NAME] President of Clinical Services (VPoCS) for an entrance conference. During the entrance conference, the surveyor asked the facility to provide the name, date of hire and employee file of any NAs that the facility had utilized since the last recertification survey which was 10/3/23. The VPoCS stated that there were no NAs in the building and that the company does not hire NAs. On 1/28/25 at 9:02 AM, the surveyor requested from the DON the staffing assignment sheets for all units and all shifts from 10/4/23 to 11/4/23. On 1/28/25 at 9:23 AM, the surveyor reviewed some of the facility provided assignment and staffing sheets which indicated the following: NA #1 (currently working as a Housekeeper NA#1/HK#1) had an assignment of 11 residents on the CNA assignment 7-3 shift form for the second floor unit on 10/6/23. She was listed as a NA on the 10/6/23 Daily Nursing Staffing Sheet for the 7-3 shift. NA #2 (no longer employed at the facility) had an assignment of 11 residents on the CNA assignment 7-3 shift form for the second floor unit on 10/6/23. She was listed as a NA on the 10/6/23 Daily Nursing Staffing Sheet for the 7-3 shift. Additional information on the CNA assignment 7-3 shift form for the second floor unit on 10/6/23 included three additional staff names that each had an assignment of 12 residents. The total number residents for the unit was 58. There was no documented evidence on the form that NA #1 and NA #2 were working with a CNA. Hospitality aid (currently working as a Housekeeper HK #2) was listed as a hospitality aid on the 11/1/23 Daily Nursing Staffing Sheet for the fourth floor 7-3 shift. On 1/28/25 at 12:05 PM, the surveyor interviewed the Director of Human Resources ([NAME]) regarding NA #1, NA #2 and the Hospitality Aid and asked her to print their time cards for 10/4/23 to 11/4/23 and provide their employee files. The [NAME] stated that she started at the facility November 15, and that she would try to print them. The [NAME] stated that the three employees were inherited and that they were from the previous company that ran the facility. She added that as far as she knew she had started after the transition and that she created her own files and did background checks. The [NAME] stated that the transition date was early 2023 and that the previous company took their employee files with them. The [NAME] stated that NA#1/HK #1 and HK #2 were housekeepers and that NA #2 worked in nursing. The surveyor requested the time cards for the current employees for 12/1/24 to 12/31/24. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 12:15 PM, the [NAME] provided the surveyor with the three employee files. She stated that the criminal background checks would be in the computer if they were not in the file and that she would ask someone to print them. A review of the employee files included the following: NA #1/HK #1 file had three disciplinary action forms and one letter dated 2/16/24 that indicated effective 2/11/24 the employee had a department change and started a new position as a HK Aide. NA #2's file was empty. Hospitality Aide/HK #2's file had one disciplinary action form and one letter dated 2/16/24 that indicated effective 2/11/24 the employee had a department change and started a new position as a HK Aide. There was no documented evidence that the facility verified that the employees had completed a TNA course, were enrolled in a CNA program and completed Module 1 at any time prior to assignment of residents or any competency evaluation. A review of NA #1/HK #1 and Hospitality Aid/HK #2 times cards indicated that their pay rate for the time period of 10/4/23 to 11/4/23 was higher than their pay rate for the time period of 12/1/24 to 12/31/24. On 1/28/25 at 12:18 PM, the surveyor asked the [NAME] if the three staff had a signed job description. The [NAME] stated that she would have to call the [NAME] President of Human Resources (VPoHR) and ask if they were uploaded. The surveyor asked the [NAME] if the employees that were still working at the facility should have complete employee files. The [NAME] stated of course and then added a lot of stuff was digital. She added that she would have to request anything prior to her starting date. The surveyor asked the [NAME] how she would know that the employees should continue to work here. The [NAME] stated that she was not sure why the signed job descriptions were not there. At that same time, the VPoHR then called [NAME] and on speaker stated that the employee's had signed job descriptions with the previous company and that only if there was a change in position would they have a signed job description on record. He added that he could try to get a copy of the job description. The VPoHR stated that after the transition to the new company everyone was onboarded but that everyone at the facility stayed in the same capacity they were with the previous company. He added that job descriptions were not signed during the acquisition (transition or change in company) or onboarding process to the new company. On 1/28/25 at 12:38 PM, the surveyor interviewed HK #1 who stated that she worked at the facility for six years and HK #2 who stated that she worked at the facility for eight years. HK #1 and HK #2 stated that they were hired by the previous company and that they both started as housekeepers. (continued on next page)

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	02/03/2025

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 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On that same date and time, the surveyor showed HK #1 and HK #2 the assignment sheets and staffing sheets that listed their names. HK#1 confirmed that she was the same person that was listed on the assignment sheet as a NA. HK #1 stated that during COVID she did a class at the facility and became a TNA. She added that after a while the TNA [waiver] stopped and that she went to school to become a CNA in 2022 but that she did not pass the written test. HK #1 stated that she was partnered with another CNA and that she helped transport and feed residents but that she did not change incontinence briefs. HK #1 stated that when she was a TNA, she changed incontinence briefs. HK #1 stated that she was not aware that she had been placed on an assignment by herself and that the last time she had been working as a NA was through December of 2023. She added that in January 2024 she returned to the Housekeeper position. At that same time, HK #2 stated that she was also a TNA during COVID and she confirmed that she was the person that was listed on the staffing sheet as a hospitality aid. HK #2 stated that she also went to school to become a CNA and that she did not pass the written test. HK #1 and HK #2 stated that when the current DON came, they were told that the facility was not going to have NAs anymore and that they were told have to get license from corporate. HK #1 and HK #2 stated that there was no documentation of their change in pay when they became housekeepers again. On 1/28/25 at 01:04 PM, the surveyor interviewed the DON who stated that he started at the facility on November 14 or 15, 2023. The surveyor showed the DON one of the staffing sheets and assignment sheet that the surveyor reviewed and asked the DON what the NA or A listed on the staffing sheet stood for. The DON stated that the NA was for a nurse aide and that he was not sure what the A was for. The DON stated that he was not at the facility at that time but that he would assume that it stood for a NA and that from the way it was written it looked like the NA had an assignment. The surveyor asked who would place those employees on the schedule. The DON stated that the Staffing Coordinator (SC) would. The surveyor asked how would the SC know if the staff were qualified. The DON stated that the SC would coordinate with the DON. The surveyor asked the DON if the staff's file should have information in it. The DON stated that the file should have information and that when he came to the facility, he stopped the use of NAs. The surveyor asked where the DON based the decision to stop the use of NAs came from. The DON stated that it was from the update on the TNA waiver. The DON stated that when he came to the facility, he adopted them and they were TNAs. He added that he asked if the staff had documentation and that the previous VP told him that they had the documentation but that she did not provide it to him. He added that at some point the staff had done the CNA program here. The DON stated that the staff were hired from the previous company and that it had been months since the transition to the current company. At that same time, the surveyor asked the DON if the staff should have a signed job description as a standard of practice. The DON stated that the staff should have a signed job description and that it was important so they knew what work they were supposed to be doing. The DON stated that the staff were Housekeepers and that when COVID came they became TNAs. He added that they went to the CNA program, and they took the written exam two times but that they did not pass it. He added that he encouraged them to go back to school. On 1/28/25 at 1:25 PM, the LNHA confirmed that the transfer from the previous company to the current company was on March 15, 2023. (continued on next page)

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F 0728 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/28/25 at 2:01 PM, the surveyor notified the LNHA, DON, ADON and VPoCS the concern that the facility had utilized TNAs or NAs without a signed job description and did not have any documented evidence that they were qualified to work as a TNA or NA. On 1/29/25 at 11:06 AM, the surveyor interviewed the SC who stated that she had worked at the facility for a little over a year and that thought she started in October or November 2023. The SC stated that the facility used to have TNAs but that the DON stopped using them when he came to the facility. She added that currently they had all CNAs and that they had NAs in the past in school and that they took them off the schedule if they did not pass the exam. On 1/29/25 at 1:39 PM, in the presence of the LNHA and DON, the VPoCS stated that the staff were part of the previous company and that they did not have a job description done. She added that she was told by the staff that they were not giving direct care. The facility did not have a policy regarding TNAs, NAs or Hospitality Aides. The facility did not provide any additional information. N.J.A.C. 8:39-43.1

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 38327 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily for 2 of 5 days in a prominent place within the facility readily accessible and visible to the residents and the visitors. This deficient practice was evidenced by the following: 1. On 1/27/25 at 8:52 AM, the survey team entered the facility and met with the Receptionist and the Director of Nursing (DON). The surveyor was unable to see the posted Nursing Home Resident Care Staffing Report (NHRCSR) not until the surveyor had to go inside the Receptionist's area where the NHRCSR was covered by a vase of flowers, which was not easily visible to residents, staff, and visitors. The posted NHRCSR was dated 1/24/25 Day Shift, 7:00 AM-3:00 PM, census of 161 that included 17 CNAs (Certified Nursing Aides) with staff to resident ratio of 1 CNA:9.5 Residents. At that same time, the surveyor asked the DON why the posted sign was dated 1/24/25 and not the date for today, and the Receptionist stated that she just forgot to change it for today's date. At the Conference room, the surveyor asked the DON what the facility's census was, and the DON stated that he would get back to the surveyor. On 1/27/25 at 9:47 AM, the surveyor met with the DON and the [NAME] President of Clinical Services (VPoCS) for an entrance conference. The DON informed the surveyor that the facility's census (total number of residents) was 161. On 1/28/25 at 8:04 AM, the surveyor entered the facility lobby and met with the Receptionist. The surveyor observed the posted NHRCSR was for 1/28/25 and a census of 161. The surveyor notified the concern regarding the posted nurse staffing report was not visible to everyone and it was for the date 1/24/25. The Receptionist informed the surveyor that after the surveyor's inquiry, the Assistant DON (ADON) told her that it should be posted in an area visible to everyone and not where next to the receptionist's desk behind the flowers. The Receptionist stated that it was usually placed where the surveyor observed it yesterday and acknowledged that it was not visible to residents and visitors. On 1/28/25 at 8:17 AM, the surveyor asked the DON regarding the posted NHRCSR and what the facility's practice where for posting it, the DON responded that it should be posted where everyone can see it in the area next to the kiosk for COVID screening. The surveyor notified the DON of the above concerns regarding the posted NHRCSR. On 2/3/25 at 12:05 PM, the survey team met with the LNHA, DON, and VPoCS for an exit conference and there was no additional information provided by the facility. 39885 (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 1/27/25 at 9:24 AM, the surveyor entered the facility. The surveyor observed the area with a table that had signage and masks and there was no staffing report posted. The surveyor then observed the desk that the receptionist sat behind and there was no staffing report posted. Upon entrance to the facility, the facility lobby area and entrance to the elevators there was no staffing posted that was accessible or visible. On 01/28/25 at 10:19 AM, the surveyor interviewed the DON regarding the posting of staffing. The DON stated that the Staffing Coordinator (SC) posted it when she was at the facility and that the supervisor posted it on the weekend. The DON stated that yesterday the posting was found on the side and that was because it was not changed yet. He added that the SC was off and it was left for person in front to post. On 1/29/25 at 11:06 AM, the surveyor interviewed the SC regarding the posting of staffing. The SC stated that she usually posted the staffing report and that the Assistant DON (ADON) and supervisors did it while she was away. The SC stated that once the schedule was set she would leave the posting in the evening for them and she would change it in the morning if the information was different when she came in at 7:30 AM. The SC stated that she assumed that the receptionist thought that the staffing that was posted was visible. On 1/28/25 at 2:05 PM, the surveyor notified the LNHA, DON, ADON and VPoCS the concern that staffing was not posted in an accessible and visible place for residents and visitors. On 1/29/25 at 1:39 PM, in the presence of the LNHA and DON, the VPoCS stated that the staff were inserviced about posting the staffing report. A review of the facility provided policy titled Posting of Staffing Policy with a reviewed date of 10/2024, included the following: Policy Explanation and Compliance Guidelines: 1. The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: a. Facility name b. The current date c. Facility's current resident census d. 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: . 2. The information posted will be: a. Presented in a clear and readable format. b. In a prominent place readily accessible to residents and visitors . (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide any additional information. N.J.A.C. 8:39-41.2 (a)(b)(c)(d)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46049 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: 1. On [DATE] at 9:16 AM, the surveyor, in the presence of the Food Service Director (FSD) observed the following during the initial kitchen tour: On a shelf in a refrigerator, there was an opened pack of shredded mozzarella cheese. The pack had an open date of [DATE] and a use by date of [DATE]. The FSD stated that the pack of cheese should not be there and took it out to be discarded. The FSD further explained the item was good for seven days after opening and that all dietary staff were responsible for ensuring expired food items were removed. 2. On [DATE] at 10:19 AM, the surveyor, in the presence of the FSD conducted a follow up tour in the kitchen. The surveyor observed Dietary Staff (DS) #1 with their hair sticking out of their hairnet on the sides behind their ears. DS #1 was serving fruits in individual cups for lunch. The surveyor asked the FSD about the observation. The FSD acknowledged all hair should be restrained in the hairnet and told DS #1 to fix her hairnet. DS #1 removed her gloves and stepped out of the food preparation area to adjust their hairnet. 3. On [DATE] at 11:26 AM, the surveyor observed tray line preparation in the kitchen. The surveyor observed DS #2 who wore a surgical mask down toward their chin, with their mustache exposed. The surveyor asked the FSD about the observation of DS #2. The FSD acknowledged his mustache should be covered. The FSD instructed DS #2 to put up his mask to cover his mustache. 4. On [DATE] at 11:28 AM, the surveyor observed DS #1 dispose removed gloves in the garbage, then went to the counter, grabbed new gloves, donned the gloves and went back to prepare for tray line to start. The surveyor asked the FSD if hand hygiene should be performed between changing gloves. The FSD replied yes. The surveyor notified the FSD about the observation of DS #1. The FSD called over DS #1 who stated that she had washed her hands twice prior to changing her gloves. The surveyor notified DS #1 of the above observation and asked if she washed her hands between the changing of the gloves. DS #1 acknowledged that she did not wash her hands at that time. DS #1 doffed (removed) her gloves and went to wash her hands. On [DATE] at 2:18 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Clinical Services (VPoCS), the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) of the observed concerns during the kitchen tour. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:57 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) #1 about the unit nutrition refrigerator for residents. LPN #1 stated items should be dated and labeled with the resident's name for personal food items. LPN #1 further explained food items were thrown out after two days from the written date. The surveyor inspected the third-floor unit nutrition refrigerator with LPN #1 and observed the following: 5. On the door of the refrigerator was an opened two cal HN (a nutritional supplement) plastic bottle which was dated [DATE] and had no name written on it. LPN #1 stated it was a supplement for a resident but was unsure for which resident. 6. In the freezer of the refrigerator, there were two 32-ounce (oz) Styrofoam cups filled with a berry-colored solid frozen item. Both cups were undated and unlabeled with a resident's name. LPN #1 did not know who the cups belonged to. The LPN acknowledged the items should have been labeled with a name and dated. LPN #1 removed the cups to be disposed. On [DATE] at 11:00 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) of the third-floor unit. The RN/UM stated that food items in the nutrition refrigerator should be labeled with the resident's name and dated. The RN/UM further explained food items were to be removed after 48 hours. The surveyor inspected the refrigerator with the RN/UM. The surveyor asked about the two cal HN, the RN/UM stated she was not sure if the supplement was being used for one resident or as a house stock item for multiple residents. 7. In the bottom left drawer of the refrigerator, a store recycling bag was labeled with Resident #75's name and dated [DATE]. Inside of the bag there were two boxes of microwavable frozen food products. The surveyor asked RN/UM about the frozen food items found in the refrigerator section. The RN/UM stated that she was not sure if the food items needed to be kept in the freezer or if the items were ok to be left in the refrigerator. 8. In the bottom right drawer of the refrigerator, there was a blue colored bag which had a plastic container of blueberries. The blueberries container was labeled [DATE] and there was no name on the food item. The RN/UM could not say who the item belonged to. The RN/UM stated that she would follow up. 9. On [DATE] at 11:10 AM, the surveyor inspected the second-floor refrigerator with LPN #2. The surveyor observed the inside of the refrigerator was dark. The light bulb fixture in the refrigerator was hanging downward from the ceiling and was empty. The LPN could not speak to what happened to the light fixture and stated it would be expected for maintenance to be notified of issue. LPN #1 was not sure if maintenance was aware of the issue. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10. On [DATE] at 11:20 AM, the surveyor inspected with the LPN/Unit Manager (LPN/UM) the fourth-floor refrigerator. The thermometer in the refrigerator read 28 degrees Fahrenheit (F). The surveyor asked the LPN/UM about the normal range for refrigerator temperatures. The LPN/UM checked the refrigerator temperature log sheet attached to the refrigerator. The LPN/UM replied, the acceptable range as indicated on the log was 34 to 40 degrees F. The LPN/UM acknowledged the temperature of 28 degrees F was outside of the expected normal range and it was protocol to notify maintenance. The LPN/UM stated she would inform the maintenance department to check and adjust the temperature. The LPN/UM provided a copy of the January refrigerator temperature log which was posted on the refrigerator. On [DATE] at 11:45 AM, the surveyor interviewed the DON about the nutrition refrigerators on the unit. The DON stated dietary were responsible for cleaning out and checking the refrigerators for outdated items. The DON explained the night shift nurses were responsible for checking refrigerator temperatures and if any issues with the refrigerators, maintenance would be informed. The surveyor informed the DON of the above observations for the unit nutrition refrigerators. The DON accompanied the surveyor to the 3rd floor unit refrigerator regarding observations. The two frozen food packages observed included the direction, keep frozen on their packaging. The DON acknowledged the food items should be kept in the freezer as instructed. The DON stated he would follow up on the surveyor's observed concerns to provide additional information. On [DATE] at 12:01 PM, the surveyor reviewed the Temperature (temp) Log for the fourth-floor nutrition refrigerator which revealed the following: The form indicated Refrigerator minimum/maximum range 34 to 40 [degrees] Fahrenheit. -On [DATE] the refrigerator temp was documented as 33 degrees. The adjustment/corrective action section was blank. -On [DATE] the refrigerator temp was documented as 30 degrees. The adjustment/corrective action section was blank. On [DATE] at 12:11 PM, the surveyor interviewed LPN #2 on the fourth floor who stated if there were maintenance issues, the nurse supervisor would be made aware, maintenance would also be contacted, and there was a maintenance log book kept at the nurses' station. The maintenance staff checked the log book during their rounds on the unit. A review of entries in the maintenance log book for [DATE] revealed one entry related to a refrigerator on the unit, dated [DATE], that documented Refrigerator to cold please check. For the entry the Corrective Measure portion was left blank. There were no other entries related to refrigerators. On [DATE] at 1:17 PM, the LNHA, VPoCS, and the DON met with the survey team. The VPoCS stated the FSD did in-service education to dietary staff on hair restraints, handwashing, and expired cheese item found. The surveyor notified the LNHA, VPoCS, and the DON of the above concerns observed with the nutrition refrigerators. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:32 AM, the LNHA, the DON, and the VPoCS met with the survey team. The VPOCS acknowledged the frozen food items should have been stored in the freezer and the resident as well as staff were educated. In-service education was provided to nursing staff was provided about appropriate labeling of items placed in the refrigerators. The refrigerator on the 4th floor was replaced with another refrigerator as the temp was not able to be adjusted within the normal range. The light for the second-floor refrigerator was fixed. There was no additional response provided by the facility. A review of the facility's Labeling and Dating System Protocol, with a last revised date of [DATE]. The policy indicated opened sliced, or shredded cheese were good for one week from their open date. A review of the facility's Media, Uniform and Hairnet Policy, with a last revised date of [DATE]. Under Procedure, it documented .Hair nets are worn and completely cover hair from front to back .Facial hair coverings will be worn to cover any facial hair . A review of the facility's Handwashing/Hand Hygiene Policy, with a last updated date of [DATE]. Under Policy Interpretation and Implementation indicated hand hygiene to be performed after removing gloves. The policy also indicated .The use of gloves does not replace hand washing/hand hygiene . A review of the facility's Refrigerators and Freezers Policy, with a last reviewed date of [DATE]. Under Policy Interpretation and Implementation documented: 1. Acceptable temp ranges are 36 to 40 degrees F for refrigerators . 5. The supervisor will take immediate action if temperatures are out of range. Actions necessary to correct the temp will be recorded on the tracking sheet, including the repair personnel and/or department contacted. 6. All food shall be appropriately dated to ensure proper rotation by expiration dates .Expiration dated on unopened food will be observed and use by dates indicated once food is opened. 7. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expires or past perish dates. NJAC 8:,d+[DATE].2(g)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 38327 Based on interview, record review, and review of other pertinent documents, it was determined that the facility failed to maintain complete, available, accurate, and readily accessible medical records. This deficient practice was identified for 2 of the 34 residents reviewed, (Residents #12 and #23). This deficient practice was evidenced by the following: 1. On 1/27/25 at 10:59 AM, the surveyor observed Resident # 12 seated on the side of the bed and informed the surveyor that they were a short-term resident and had been in and out of the facility more than three times hospitalization s due to a heart condition. The surveyor reviewed the medical records of Resident #12, and revealed the following: The Admission Record (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; major depressive disorder (recurrent and mild), cardiac arrhythmia (irregular heartbeat) unspecified, unspecified atrial fibrillation (an irregular and often very rapid heart rhythm), essential hypertension (elevated blood pressure), and type 2 diabetes mellitus without complications. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool, with an assessment reference date (ARD) of 11/20/24, under Section C Cognitive Patterns revealed a brief interview for mental status (BIMS) score of 15 of 15, which reflected that the resident had intact cognition. Further review of the MDS revealed that the resident had two unplanned hospitalization s for 2024. A review of the medical records revealed that there was no Universal Transfer Form (UTF is to ensure that accurate communication of pertinent clinical patient care information is conveyed at the time of a transfer between healthcare facilities or programs). On 2/3/25 at 8:22 AM, the surveyor asked the Director of Nursing (DON) for a copy of the resident's UTF for 2024, and the DON responded that he would get back to the surveyor. On 2/3/25 at 10:33 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, and [NAME] President of Clinical Services (VPoCS), and the surveyor asked who was responsible for making sure the record was accurate and available. The DON stated that we do review as a clinical team, the managers, nurses, DON, and ADON the medical records to make sure records were accurate and available. The surveyor followed up with the UTF of Resident #12, and the DON stated he would get back to the surveyor. (continued on next page)

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	02/03/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/3/25 at 11:01 AM, the DON provided a copy of the UTF with the handwritten date for 9/10/24 and the DON confirmed that the UTF was undated and just added the date for 9/10/24. He further stated that there were no other UTFs that he could find. The surveyor notified the DON of the above concerns that the surveyor did not find the UTF in the resident's files (both electronic and paper chart) and asked the DON where he found the record, and the DON did not respond. 2. On 1/27/25 at 10:59 AM, the surveyor observed Resident # 23 lying on the bed with BIPAP (Bilevel positive airway pressure, is a machine that helps resident breathe and a form of noninvasive ventilation) and nebulizer (neb) machine on top of the nightstand table. On 1/28/25 at 11:16 AM, the surveyor observed the resident lying on the bed. The resident informed the surveyor that they use the oxygen (O2) as needed (PRN) and the BIPAP at night. The surveyor reviewed the medical records of Resident #23 and revealed: A review of the AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to sleep apnea (a potentially serious sleep disorder in which breathing repeatedly stops and starts) and chronic obstructive pulmonary disease (COPD, is a common, preventable and treatable disease that is characterized by persistent respiratory symptoms like progressive breathlessness and cough) unspecified. A review of the most recent quarterly MDS, with an ARD of 12/6/24, Section C Cognitive Patterns a BIMS score of 15 out of 15, which reflected that the resident's cognition was intact. A review of the Order Summary Report (OSR) revealed a Physician Order (PO) dated 7/18/24, to apply BIPAP settings: 18/6 FIO2 (fraction of inspired oxygen (FiO2) is the concentration of O2 in the gas mixture) 30%, frequency: on at HS (hours of sleep, also known as bedtime) and off in the AM (morning) for hypercapnia (a condition that occurs when a person has too much carbon dioxide in their bloodstream) and remove per schedule. The above order for BIPAP was transcribed to the electronic Treatment Administration Record (eTAR) and signed by nurses as administered, at 9:00 PM and removed at 8:00 AM for September, October, November, December 2024, and January 2025. A review of the Progress Notes (PN) that were electronically signed by the Nurse Practitioner (NP) dated 9/12/24, 11/14/24, and 1/16/25 reflected that the assessment and plan included CPAP (continuous positive airway pressure, is a machine that uses mild pressure to keep the breathing airways open during sleep) at night, not using CPAP at night per staff. Further review of the PN revealed that there was no evidence that the nurse documented that Resident #23 was not using the BIPAP. There was no evidence that the resident was on CPAP. On 2/3/25 at 8:22 AM, the surveyor notified the DON of the concern with the NP's PN about CPAP. A review of the facility's Medical Records Policy with a reviewed date of 10/2024, which was provided by the DON revealed that each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation . (continued on next page)

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	315295	A. Building B. Wing	02/03/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/03/25 at 12:05 PM, the survey team met with the LNHA, DON, and VPoCS for an exit conference, and there was no additional information provided by the facility. NJAC 8:39-23.2 (a)(b); 35.2 (d)(6)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48782 Based on observation and interview on 1/27/2025 in the presence of the Director of Maintenance (DM), it was determined that the facility failed to ensure that the devices used to identify call bell notifications were functioning properly. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation at 1:28 PM, revealed that the call bell system did not give audible or visual notification of the activation of the call bell system at the nurse's station when it was test for room [ROOM NUMBER]. Upon further investigation by the DM, it was discovered that the call bell annunciator at the nurse's station was not plugged in. In an interview at the time, the DM confirmed that the call bell annunciator panel was unplugged, and confirmed that with the annunciator panel unplugged, any activation of the call bell system from any room on floor 4 would not be heard or seen at the nurse's station. The DM plugged the call bell annunciator back in and informed the nursing staff that they had to be careful not to unplug it. The facility's Administrator was informed of the deficient practices at the Life Safety Code exit conference on 1/29/2025 at 12:00 PM. N.J.A.C 8:39-31:2(e)