STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Prospect Heights LLC	336 Prospect Ave 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. 40823 C #: NJ00171849 Based on interview and record review on 4/15/24 and 4/16/24, it was determined that the facility failed to accurately encoded a resident's wound in Minimum Data Set (MDS) assessment for 1 of 3 residents (Resident #1) reviewed for MDS accuracy. This was evidenced by the following: Reference: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 October 2023, under Section M: Skin Conditions . M0210 Unhealed Pressure Ulcers/Injuries .Coding Instructions Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days. Code 0, no: if the resident did not have a pressure ulcer/injury in the 7-day look-back period. Then skip to M1030, Number of Venous and Arterial Ulcers. Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Coding Tips If an ulcer/injury arises from a combination of factors that are primarily caused by pressure, then the area should be included in this section as a pressure ulcer/injury. Under DEFINITIONS STAGE 1 PRESSURE INJURY An observable, pressure related alteration of intact skin whose indicators, as compared to an adjacent or opposite area on the body, may include changes in one or more of the following parameters .persistent redness in lightly pigmented skin, whereas in darker skin tones, the injury may appear with persistent red, blue, or purple hues. NON-BLANCHABLE Reddened areas of tissue that do not turn white or pale when pressed firmly with a finger or device. According to the admission record, Resident #1 was admitted with diagnoses that included but not limited to: Difficulty in Walking, Adult Failure to Thrive, and Protein Calorie Malnutrition. The MDS, an assessment tool dated 12/10/23, a Comprehensive assessment, indicated that Resident #1's cognition was intact and was able to participate substantial/maximal assistance during activity of daily living with. The MDS further indicated under Section M (used to assess skin condition during a 7-day look-back period), M0210, Unhealed Pressure Ulcers/Injuries indicated that the Resident did not have a pressure ulcer. A review of the Resident's SKIN INTEGRITY/DIAGRAM (SID), dated 12/8/23, under DIAGRAM, reflected that Resident #1 had sacral pressure ulcer, described as Redness. (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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Order Summary Report (OSR), dated 4/15/24, revealed on 12/6/23 an order for PREVENTATIVE SKIN CARE: APPLY BARRIER CREAM AFTER CLEANSING WITH SOAP AND WATER EVERY SHIFT AND AS NEEDED S/P [status post] EACH INCONTINENT EPISODE. The TREATMENT ADMINISTRATION RECORD (TAR) for the month of 12/2023 revealed the aforementioned order. The TAR further revealed that the BARRIER CREAM was applied to the Resident's skin from 12/7/23. During the interview with the Surveyor on 4/16/24 at 1:41 p.m., the Unit Manager/Licensed Practical Nurse (UM/LPN #1) confirmed what was documented on the SID. During the interview with the Surveyor on 4/15/24 at 2:44 p.m., the MDS Coordinator (MDSC) confirmed that previous MDS staff (who no longer work in the facility) miscoded the 12/10/23 assessment, Section M. The job description for MDS Nurse Job Description, undated, indicated Duties and Responsibilities Conduct and coordinate the development and completion of the resident assessment (MDS) in accordance with current rules, regulations and guidelines that govern the resident assessment . A review of the facility policy titled MDS Completion and Submission Timeframes, dated 10/2019, indicated Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes . NJAC 8:39-11.2(e)(1)

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F 0657 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40823 COMPLAINT#: NJ00171849 Based on observations, interviews, medical record reviews, and review of other pertinent facility documentation on 4/15/24 and 4/16/24, it was determined that the facility failed to implement and revise care plan (CP) interventions for a resident who was experiencing pain resulted to a decline in condition, and failed to follow the facility policy for Pain and Comprehensive Care Plan for 1 of 3 residents (Resident #1) reviewed for implementation and revision of CP. This deficient practice was evidenced by the following: According to the admission record, Resident #1 was admitted with diagnoses that included but not limited to: Fall, Difficulty in Walking, and Adult Failure to Thrive. The Minimum Data Set (MDS), an assessment tool dated 12/10/23 indicated that Resident #1's cognition was intact and was able to participate substantial/maximal assistance during activity of daily living with. Review of the CP for Resident #1, initiated on 12/12/23 and revised on 2/15/24 indicated that Resident #1 had pain related to Disease Process. The CP also indicated a goal that Resident #1 will not have an interruption in normal activities due to pain through the review date. Interventions initiated on 2/12/23 and revised on 2/15/24 (after Resident had been discharged), included but not limited to: -Administer analgesia as per orders, to give half hour before treatments or care. -Monitor/record/report to Nurse any sign and symptoms of non-verbal pain; Changes in breathing (noisy, deep/shallow, labored, fast/slow): Vocalizations (grunting, moans, yelling out, silence): Mood/behavior (changes, more irritable, restless, aggressive, squirmy, constant motion): Eyes (wide open/narrow slits/shut, glazed, tearing, no focus): Face (sad, crying, worried, scared, clenched teeth, grimacing) Body (tense, rigid, rocking, curled up, thrashing). -Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. -Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care. The Order Summary Report (OSR), dated 4/15/24, revealed that on 12/7/23 and discontinued on 1/17/24 an order for Acetaminophen Tablet 325 milligram (mg), give 2 tablets by mouth every 4 hours as needed for Mild Pain, on 1/17/24 an order for Acetaminophen Tablet 325 mg, give 2 tablets by mouth every 4 hours as needed for Mild Pain for Pain Scale (PS) of 1 to 3, and Pain Screen every shift on 12/7/24. (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 0657 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The MEDICATION ADMINISTRATION RECORD (MAR) for 1/2024 and 2/2024, revealed the aforementioned orders. The 1/2024 and 2/2024 MAR for Pain Screen revealed that Resident #1 was in pain on - 1/22/24 during 7:00 a.m. to 3:00 p.m. shift, PS of 4, - 1/23/24 during 7:00 a.m. to 3:00 p.m. shift, PS of 3, - 1/25/24 during 3:00 to 11:00 p.m. shift, PS of 3, - 2/2/24 during 7:00 a.m. to 3:00 p.m. shift, PS of 9, and - 2/6/24 during 11:00 p.m. to 7:00 a.m. shift, PS of 3. In addition, review of the Residents Occupational Therapy Treatment Encounter Notes ([NAME]), documented by the Certified Occupational Therapy Aide (COTA) on 1/25/24 Resident #1 reported 9/10 pain in R [right] knee and BUE [bilateral upper extremities] hands. Nurse was notified. On 1/29/24, Resident #1 verbalized of pain and feeling very weak and stiff, Pt has had steady decline in skilled interventions due to pain and fatigue. Pts vitals were checked during session and BP [blood pressure] 157/73 . On 1/30/24 Resident #1 reported 8/10 pain in right knee and right upper thigh .continuously verbalizes pain and is feeling very weak with no appetite. Pt has had steady decline in skilled interventions due to pain and fatigue. Pts vitals were checked during session and BP 163/72 . On 1/31/24, Resident #1 has steady decline in skilled interventions due to pain and fatigue .Barriers impacting Treatment: decreased attention skills, pain consistently, inconsistent ability to concentrate and attend to therapeutic intervention and decreased inhibition. On 2/1/24, Resident #1 Continuously verbalizes pain and is feeling very weak with no appetite. Pt. [patient] has had steady decline in skilled interventions duet to pain and fatigue. Pt. family and nursing is aware of the status of the patient. Review of the Resident's progress note (PN) dated 1/31/24 at 10:13 documented by the Resident's Nurse Practitioner (NP) that the Resident was unable to provide subjective complaint. Per staff, fluctuation in alertness and responsiveness. Often not eating food offered. The NP further documented Advanced care planning: discussed worsening condition with pt. son. Poor appetite despite stimulant. Will change stimulant despite likey little to no effect. 3 Day calorie count ordered. Discussed codestatus. Reviewed in detail DNR/DNI and poor likelihood of meaningful recovery given overall condition and age. Remains full code. Discussed hospice vs palliative care. Accepting of palliative consult. Plan discussed with nursing, social services and therapy team . The PN did not indicate that the pain was address during the advanced care planning on 1/31/24. There was no indication in the Resident's MR that Resident #1's pain was managed when she/he was experiencing pain on the aforementioned dates and time which was not according to the Resident's CP. In addition, there was no indication that the Resident's CP was revised when her/his PS was above 3. (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 0657 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During the telephone interview with the Surveyor on 4/17/24 at 5:33 p.m., LPN #3, who worked during the shift of 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. The LPN stated that at times, Resident #1 would cry for pain and the Resident only have as needed (PRN) medication and did not have stronger medication. The LPN added at times when the Resident was in pain, they would reposition her, they tried to move the Resident around, would talk to [her/him], she added nothing we can give to her stronger than Tylenol to alleviate [her/his] pain, [Resident #1] would scream and everybody at the facility would hear [her/him], [she/he] would be in agonizing pain. LPN #3 was unable to recall if the Resident's pain, PS was 4 on 1/22/24 and PS of 9 on 2/2/24 was addressed. During the interview with the Surveyor on 4/16/2024 at 3:33 p.m., the Director of Nursing (DON), Regional Clinical Nurse, and the administrator was notified that the staff failed to implement the Residents CP when her/his PS was 3 and failed to address and revise Resident's CP when the Resident experienced pain above PS of 3. The facility policy titled Pain, undated indicated The facility will ensure pain management is provided to resident who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain .Pain Management and Treatment 1. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. 2. The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or in situations that may be associated with pain or may be included as a specific pain management need or goal .Monitoring, Reassessment and Care Plan Revision a. Facility staff will reassess resident's pain management at established intervals for effectiveness and/or adverse consequences such as .Physical dependence .Increases sensitivity to pain .Depression .b. If re-assessment findings indicate pain not adequately controlled, the pain management regimen and plan of care will be revised as indicated . The facility policy titled Comprehensive Care Plan, undated indicated Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed . NJAC: 8:39-27.1 (a)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 40823 COMPLAINT: # NJ00171849 Based on observation, interview, record review, and pertinent facility documents, it was determined that the facility failed to provide assistance in toileting service to 1 of 3 sampled residents (Resident #2). This deficient practice is evidenced by the following: According to admission record, Resident #2, was admitted with diagnosis which included but not limited to: Urinary Tract Infection, Metabolic Encephalopathy, Muscle Weakness, and Need Assistance with Personal Care. The form COGNITIVE IMPAIRMENT SLP SCREEN, signed and dated by the SLP on 4/11/2024, reflected that Resident #2's cognition was moderately impaired. Resident #2's care plan (CP), initiated on 4/9/24 and revised on 4/15/24, indicated that Resident #2 had actual impairment to skin integrity of sacrum r/t impaired mobility, incontinence, and nutritional concerns. Intervention included but not limited to, to be assisted with general hygiene and comfort measures. The CP, initiated on 4/10/24 further indicated that the Resident had an activity of daily living selfcare performance deficit related to (r/t) impaired balance, limited physical mobility. The Minimum Data Set (MDS), an assessment tool dated 4/13/24, indicated that the Resident's cognition was moderately impaired and needed assistance with Activities of Daily Living (ADLs). The MDS further indicated that the Resident was incontinent of bowel and bladder. During a skin check on 4/15/24 at 10:36 am, in the presence of the Unit Manager/Licensed Practical Nurse (UM/LPN #1) and Certified Nursing Assistance (CNA #1), CNA #1 was observed providing morning care to Resident #2. Resident #2 was lying on her/his left side in bed sleeping but arousable. The surveyor and UM/LPN #1 observed Resident #2's incontinence brief was soaked and wet. The Resident was observed lying on a yellow stained 2 draw sheets and bed sheet, Residents low to mid back had fecal matter. The CNA continued to provide care. According to the CNA, UM/LPN #1, LPN #2 (assigned nurse), they did not check or change the Resident's incontinence underwear since the beginning of the shift. During an interview with CNA #1 on 4/16/24 at 1:25 p.m., the CNA stated that she did not see the Resident until morning care with the surveyor and the UM/LPN. She further stated that she did not get a change to check the Resident if she/he was wet or if needed to be changed. She stated that residents have to be checked for wetness every 2 hours and if the resident is soiled, they needed to be changed right away and does not need to wait for the next 2 hours. The CNA explained that she did not have a chance to check Resident #2 if she/he needed to be changed at the beginning of the shift because they were short of staff. According to 4/15/2024 third floor schedule, the third floor had 3 CNAs. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	According to the third floor Daily Census, dated 4/15/24, the third floor had 27 residents. Review of the CNA job description, under Specific Job Function .Make resident comfortable .Keep resident dry (i.e., change gown, clothing, linen, etc., when it becomes wet or soiled) Change bed linens .Assist resident with bowel and bladder functions . Review of the facility's policy titled Incontinent Care, undated, reflected It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and conform, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Review of the facility's policy titled Activity of Daily Living (ADLs), Supporting Policy Statement Residents [will] be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activity of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs as independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with .c. Elimination (toileting) . NJAC 8:39-27.1(a)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40823 COMPLAINT: # NJ00171849 Based on interviews, review of the medical records, and review of other pertinent facility documents, on 4/15/24 and 4/16/24, it was determined that the facility failed to consistently follow residents' care plan (CP), evaluate pain, and ensure that pain medications were administered according to the physician's orders (PO's) for residents who was experiencing pain. The facility also failed to follow its policy titled Pain for 1 of 3 residents (Resident #1) reviewed for pain management. This deficient practice was evidenced by the following: According to the admission record, Resident #1 was admitted with diagnoses that included but not limited to: Fall, Difficulty in Walking, and Adult Failure to Thrive. The Minimum Data Set (MDS), an assessment tool dated 12/10/23 indicated that Resident #1's cognition was intact and was able to participate substantial/maximal assistance during activity of daily living with. The MDS further indicated that Resident #1 was receiving as needed pain medications or was offered and declined. Review of the CP for Resident #1, initiated on 12/12/23 and revised on 2/15/24 indicated that Resident #1 had pain related to Disease Process. The CP also indicated a goal that Resident #1 will not have an interruption in normal activities due to pain through the review date. Interventions initiated on 2/12/23 and revised on 2/15/24 (after Resident had been discharged), which included but not limited to: -Administer analgesia as per orders, to give half hour before treatments or care. -Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. The Order Summary Report (OSR), dated 4/15/24, revealed on 1/17/24 an order for Acetaminophen Tablet 325 milligram (mg), give 2 tablets by mouth every 4 hours as needed for Mild Pain, Pain Scale (PS) of 1 to 3 and Pain Screen every shift on 12/7/24. The MEDICATION ADMINISTRATION RECORD (MAR) for 1/2024 and 2/2024, revealed the aforementioned orders. The MAR for 1/2024 and 2/2024 Pain Screen revealed that Resident #1 was in pain on - 1/23/24 during 7:00 a.m. to 3:00 p.m. shift, PS of 3, - 1/25/24 during 3:00 to 11:00 p.m. shift, PS of 3, and - 2/6/24 during 11:00 p.m. to 7:00 a.m. shift, PS of 3. There was no indication in the Resident's MR that the Acetaminophen 325 mg 2 tablets was administer to the Resident when she/he has PS of 1 to 3, which was not according to the PO's. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- 1/22/24 during 7:00 a.m. to 3:00 p.m. shift, PS of 4 and - 2/2/24 during 7:00 a.m. to 3:00 p.m. shift, PS of 9 There was no indication in the Resident's MR that the Resident's pain above PS of 4 was address which as not according to the resident CP. Review of Resident #1 Occupational Therapy Treatment Encounter Notes ([NAME]), documented by the Certified Occupational Therapy Aide (COTA) the following. -On 1/25/24, Resident #1 reported 9/10 pain in R [right] knee and BUE [bilateral upper extremities] hands. Nurse was notified. -On 1/29/24, Resident #1 verbalized of pain and feeling very weak and stiff, Pt has had steady decline in skilled interventions due to pain and fatigue. Pts vitals were checked during session and BP [blood pressure] 157/73 -On 1/30/24 Resident #1 reported 8/10 pain in right knee and right upper thigh .continuously verbalizes pain and is feeling very weak with no appetite. Pt has had steady decline in skilled interventions due to pain and fatigue. Pts vitals were checked during session and BP 163/72 . -On 1/31/24, Resident #1 has steady decline in skilled interventions due to pain and fatigue .Barriers impacting Treatment: decreased attention skills, pain consistently > 8, inconsistent ability to concentrate and attend to therapeutic intervention and decreased inhibition. -On 2/1/24, Resident #1 Continuously verbalizes pain and is feeling very weak with no appetite. Pt. [patient] has had steady decline in skilled interventions duet to pain and fatigue. Pt. family and nursing is aware of the status of the patient. There was no indication in the Resident's MR that Resident #1's pain above PS of 3 was addressed on the aforementioned dates and time, as indicated in the [NAME]. During the interview with the Surveyor on 4/16/24 at 10:01 a.m., the Occupation Therapist/Director of Rehab (OT/DOR) who was also reviewing the COTA's note on her laptop during the interview, the OT/DOR stated that the Resident started declining on 1/25/24, the Resident continued rehab, however, Resident #1 was refusing and was unable to participate. The OT/DOR further stated that the rehab for Resident #1 was discontinued because she was not progressing. According to OT/DOR, Resident #1 verbalized of pain and feeling week. She further stated I'm sure the COTA reported to nursing because that's how we do it. Unfortunately, she did not document.She further stated, If not documented, it didn't happen. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During the interview with the Surveyor on 4/16/24 at 10:52 a.m., the COTA confirmed what was documented on the [NAME]. The COTA stated that Resident #1 started complaining of pain towards the end of 1/2024. The COTA confirmed that Resident #1 declined due to pain and fatigue as documented on the [NAME]. The COTA explained that during the session, when Resident verbalized of pain, she would stop the session, stop the passive range of motion and continue the feeding task during mealtime. The COTA stated that she communicated to nursing that the Resident was in pain (unable to give specific date and time). The COTA explained that when a patient is in pain, it affects the outcome or plan of treatment, so its hard for the goal to be met because the patient will not participate, the patient did not meet the goal because she was in pain. The COTA admitted that the communications to nursing was not documented and said to document any interaction or any care provided to Resident, from now on I would need to document that I notified the nurses. Document to show proof that it was communicated. If not documented means it didn't happen. During the interview with LPN #4 on 4/16/24 at 3:53 p.m., who was assigned to Resident #1 on the [NAME] aforementioned dates, she stated that she did not receive a report from the COTA that the Resident was in pain. According to the LPN, if she was made aware, she would have assessed the Resident and would give the pain medication. During the telephone interview with the Surveyor on 4/17/24 at 5:33 p.m., LPN #3, who worked during the shift of 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. The LPN stated that at times, Resident #1 would cry for pain and the Resident only have as needed (PRN) medication and did not have stronger medication. The LPN added at times when the Resident was in pain, they would reposition her, they tried to move the Resident around, would talk to [her/him], she added nothing we can give to her stronger than Tylenol to alleviate [her/his] pain, [Resident #1] would scream and everybody at the facility would hear [her/him], [she/he] would be in agonizing pain. LPN #3 was unable to recall when the Resident's PS was 4 on 1/22/24 and PS of 9 on 2/2/24 was addressed. The facility policy titled Pain, undated indicated The facility will ensure pain management is provided to resident who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences .Pain Management and Treatment 1. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. 2. The interventions for pain management will be incorporated into the components of the comprehensive care plan, addressing conditions or in situations that may be associated with pain or may be included as a specific pain management need or goal .6. Non-pharmacological interventions will be included but are limited to: a. Environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning) b. Loosening any constructive bandage, clothing or device c. applying splinting (e.g., pillow or folded blanket) d. Physically modalities (e.g., cold compress, warm shower/bath, massage, turning and reposition) e. Exercises to address stiffness and prevent contractures as well as restorative nursing program to maintain joint mobility f. Cognitive/behavioral interventions (e.g., music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and education about pain) 7. Pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain. The interdisciplinary team is responsible for developing a pain management regimen that is specific each resident who has pain or who has the potential for pain. The following are general principles the facility will utilize for prescribing analgesics . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Prospect Heights LLC	336 Prospect Ave 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 0697 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	NJAC 8:39-27.1(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. Building B. Wing	04/16/2024

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 40823 COMPLAINT: # NJ00171849 Based on observations, interviews, and record review, as well as review of pertinent facility documents on 4/15/24 and 4/16/24, it was determined that the facility failed to ensure there was adequate staffing to provide for the needs of residents for 1 of 3 Residents (Resident #1) observed for nursing care. This deficient practice is evidenced by the following: According to admission record, Resident #2, was admitted with diagnosis which included but not limited to: Urinary Tract Infection, Metabolic Encephalopathy, Muscle Weakness, and Need Assistance with Personal Care. Resident #2's care plan (CP), initiated on 4/9/24 and revised on 4/15/24, indicated that Resident #2 had actual impairment to skin integrity of sacrum r/t impaired mobility, incontinence, and nutritional concerns. Intervention included but not limited to, to be assisted with general hygiene and comfort measures. The CP, initiated on 4/10/24 further indicated that the Resident had an activity of daily living selfcare performance deficit related to (r/t) impaired balance, limited physical mobility. The Minimum Data Set (MDS), an assessment tool dated 4/13/24, indicated that the Resident's cognition was moderately impaired and needed assistance with Activities of Daily Living (ADLs). The MDS further indicated that the Resident was incontinent of bowel and bladder. During a skin check on 4/15/24 at 10:36 am, in the presence of the Unit Manager/Licensed Practical Nurse (UM/LPN #1) and Certified Nursing Assistance (CNA #1) was observed providing morning care to Resident #2. Resident #2 was lying on her/his left side in bed sleeping but arousable. The surveyor and UM/LPN #1 observed Resident #2's incontinent brief was soaked and wet. The resident was observed lying on a yellow stained 2 draw sheets and bed sheet (misture of urine and feces). Residents low to mid back had fecal matter. The CNA provided care incontinent care to Resident #2. According to the CNA, UM/LPN #1, and LPN #2 (assigned nurse), they did not check or change the Resident's incontinence underwear since the beginning of the shift from 7:00 a.m. During an interview with CNA #1 on 4/16/24 at 1:25 p.m., the CNA stated that she did not provide care to the Resident until 10:36 a.m. According to the CNA she did not get a chance to check the Resident if she/he was wet or if needed to be changed because because they were short staff today. According to the third floor Daily Census, dated 4/15/24, the third floor had 27 residents and 3 CNAs. CNA #2 (CNA assigned to Resident #1 on 4/14/24 during the night shift) was not available for an interview on 4/15/24 and 4/16/24 during the survey. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315460	A. Building B. Wing	04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Prospect Heights LLC	336 Prospect Ave Hackensack, NJ 07601

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the CNA job description, under Specific Job Function .Make resident comfortable .Keep resident dry (i.e., change gown, clothing, linen, etc., when it becomes wet or soiled) Change bed linens .Assist resident with bowel and bladder functions . NJAC 8:39-27.1(a)