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	01/29/2026

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 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. Based on observation, interview, record review, and policy review, it was determined that the facility failed to; a.) store potentially hazardous foods in a manner to prevent food borne illness, b.) failed to properly label and date food items to ensure safety and prevent contamination, c.) failed to discard expired and unsafe food in accordance with facility policy, d.) failed to maintain kitchen equipment and utensils in a sanitary manner to prevent contamination from foreign substances and the potential for development of food borne illness, and e.) failed to maintain essential kitchen equipment in safe operating condition. This deficient practice was evidenced by the following: On 1/21/26 at 09:45 AM, in the presence of the Food Services Director (FSD), the surveyor observed the following:Dry Storage Area:1.In the dry storage room, the surveyor observed six dented cans located on the can storage rack that was accessed by kitchen staff for meal preparation. The surveyor observed three cans containing peaches and three cans containing marinara sauce. Each dented can had a dent measuring 11/2 - 2 inches along the seam. The surveyor observed a designated Dented Can area located on the bottom shelf of a separate shelving unit that contained additional dented cans. The FSD immediately removed the six dented cans from the can storage rack after surveyor observation and placed them in the Dented Can area. Walk-In Freezer #1:2.The surveyor observed 12 single serve ice cream servings prepared from a large ice cream container in small plastic clear containers on a tray on the shelf of the freezer with no label identifying the date of preparation or the date of use-by. The FSD stated that her expectation was that the items were from the previous day but the items did not contain a label. Walk-In Freezer #2:3.The surveyor observed a box of items containing muffins and bread that the FSD stated were gluten free. In the open box, the surveyor observed a container of muffins that contained two muffins with two missing. The lid on the muffins was off and did not contain a label dating when the item was opened or when the item should be used by. In addition, the surveyor observed the gluten free box contained two bags of bagels, each with two bagels left inside. The bags were not closed or sealed. The bags of bagels also did not contain a date indicating when they were opened and when they should be used by. At the bottom of the box, the surveyor observed a single bagel wrapped in saran wrap with no label indicating when it was opened or when the item should be used by. The FSD stated she was not sure how long the loose item was in the freezer. The FSD discarded all the items that did not have a label following surveyor observation. Walk-In Refrigerator #1:4.The surveyor observed a large plastic container of Italian dressing with a label that noted Open date - 1/14/26 and EOD (End of Day) date 1/20/26. The FSD removed the item from the refrigerator and stated the item should have been removed and discarded on the previous day, on 1/20/26. The FSD discarded the item at that time. 5.The surveyor observed sliced turkey wrapped in saran wrap on a tray with lunch meat items. The sliced turkey had an open date of 1/18/26 and an EOD date 1/20/26. The FSD stated that the item should have been used or discarded the previous day and then proceeded to dispose of the item. Kitchen Equipment:6.Above the stove, the surveyor observed the ventilation hoods or exhaust hoods above the stove which contained 14 hoods. The surveyor observed two of the 14 hoods contained small bends in the bottom of the hood closest to the floor that created a 1/4 inch gap. 7.The surveyor observed a six burner stove top with a black crusted substance that (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was easily lifted with the tip of the surveyor's pen. The FSD stated that the stove tops were cleaned daily. The FSD stated that the stove is old and the lining is old and anything that drips sticks to it. 7.The surveyor observed black crusted substances located in the bottom corners of the oven that were easily lifted with the tip of the surveyor's pen. 8.The surveyor observed two of two frying pans with crusted black substance lining the entire pan on both pans. Follow-Up Kitchen Tour on 1/22/26:9.The surveyor observed an additional frying pan containing crusted black substance around the perimeter of the pan on the inside and outside with caked black substance on the area where the handle and the pan meet. This was identified in front of the FSD and she acknowledged the concern and stated she would get rid of the pan. 10.The surveyor observed no trash bin at the second hand washing station to dispose of paper towels. This concern was addressed with the FSD and she stated, the hand washing station should have a small trash bin to throw away paper towels. Maybe it got moved last night when they were cleaning them. A review of the facility's Dry Food Storage Policy which requires that unacceptable, dented canned good will be reported and returned/discarded promptly . A review of the facility's Food Storage Policy which requires that all foods are securely covered, dated, and labeled . A review of the facility's Kitchen cleaning policy which requires that staff shall maintain the sanitation of the kitchen . During an interview on 1/22/26 at 02:00 PM, the surveyor brought the above concerns to the attention of the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). On 1/29/26 at 1:50 PM, the survey team met with the LNHA, DON and [NAME] President of Clinical Services for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-17.2(g)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interviews and review of pertinent documentation, it was determined that the facility failed to ensure the facility-wide assessment was revised and included the contingency plan that address the facility's need with regard to staffing. This failure had the potential to affect all 117 residents who currently live in the facility.This deficient practice was evidenced by the following:According to the CMS (Centers for Medicare & Medicaid Services) Ref: QSO-24-13-NH, dated 6/18/24, Subject: Revised Guidance for Long-Term Care Facility Assessment Requirements, Memorandum Summary: Under the Minimum Staffing Standards for Long-Term Care (LTC) Facilities and Medicaid Institutional Payment Transparency Reporting final rule, the requirements forFacility Assessment have been revised. These new provisions become effective 90 days after publication and must be implemented by 8/8/24.S483.71(c) The facility must use this facility assessment to:S483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs asidentified through resident assessments and plans of care as required in S 483.35(a)(3).S483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. On 1/21/26 at 9:50 AM, the surveyor met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) during an entrance conference. The LNHA stated that the current census was 117 (total number of residents). The surveyor requested from the LNHA and DON a copy of the most updated Facility Assessment (FA). On that same date and time, the LNHA confirmed that the facility did not utilize agency staff for staffing needs for nursing. The LNHA further stated that the facility was not on a COVID outbreak. A review of the provided FA, with an approved date of 7/29/25, that was provided by the LNHA, revealed that the FA will be reviewed and updated, as necessary, and at least annually. Whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment, the Administrator will ensure that all relevant elements of the assessment is reviewed and updated .Contingency Planning for Staffing: In the case of an emergent event, the facility's emergency plan will be activated. If the event does not rise to the level of activation of the facility's emergency plan the facility will: Refer to COVID contingency staffing pattern/plan. On 1/29/26 at 10:29 AM, the surveyor met with the LNHA and DON for QAPI (Quality Assurance Performance Improvement) meeting. The LNHA confirmed the provided 7/29/25 FA was the most updated one. The LNHA stated that the FA was reviewed and updated quarterly, during the facility's QAPI meeting, annually, and as needed if there would be a global change identified by CMS. The surveyor asked the LNHA and DON if they were aware of the updated regulatory requirements with minimum staffing of the CMS, and there was no response. On that same date and time, the surveyor asked the LNHA as to why the update regulatory requirement from the CMS effective 8/28/24, with regard to contingency plan was not followed in their FA, and the LNHA did not respond. On 1/29/26 at 1:50 PM, the survey team met with the LNHA, DON, and [NAME] President of Clinical Services for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-33.2(b)(c)(13)(d); 34.1(a)

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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** Complaint NJ#384180Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide a safe, clean, and comfortable homelike setting. This deficient practice was identified for 4 of 4 units and common areas, and was evidenced by the following:The deficient practice was evidenced by the following: 1.On 1/21/26 at 10:31 AM, during the initial tour of the facility, Surveyor #1 (S #1) entered the 3rd floor dining/activity area and observed the wall mounted thermostat. The thermostat indicated a temperature (temp) of 67 degrees Fahrenheit (deg F). On that same day, at 10:50 AM, S #1 entered the 4th floor dining/activity area and observed seven square tables in the room, 4 of the 7 tables were observed to have the thin laminate surface peeling back leaving a sharp edge and a wood surface underneath. On 1/27/26 at 11:28 AM, S #1 entered the 4th floor dining/activity room and observed the wall mounted thermostat and indicated a temp of 66.7 def F. On 1/28/26 at 12:33 PM, the facility Administrator in Training (AIT) provided to the survey team, documents Environmental Temp and Safety Rounds. S #1 reviewed the documents and did not reflect any temp measurements of the dining/activity areas on any of the facility floors. On 1/28/26 at 1:47 PM the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and S #1 notified them of the above concerns. On 1/29/26 at 11:44 AM, the survey team met with the LNHA and DON for responses to above concerns. The LNHA stated that the building was acquired approximately 2 1/2 years prior and infrastructure improvements were made. The LNHA stated that there were unseasonable temp, and it was exceptionally cold with temp in the 10 to 20 degrees F range. The LNHA stated that there was a new statute in New Jersey for Long Term Care Facilities that gave different temp regarding air conditioning and heating and that was what they were following. The LNHA stated that the 3rd Floor dining area was not being used and was decommissioned. On that same date and time, Surveyor #2 (S #2) stated that there were no notifications on the doors of the dining area that was not being used, or anywhere else in the facility and the doors were able to be opened. S #2 further stated that there were no notifications either to the survey team, visitors, residents, and staff that the dining room was decommissioned, and if they were, should there be a prior notifications, and the LNHA did not respond. The LNHA did not provide any further pertinent information. A review of the memorandum from the Executive Director Division of Certificate of Need and Licensing, dated 4/14/22, that was provided by the LNHA, Re: Statutory Amendments Regarding Temperature Level Standards Pursuant to NJSA 26:2H-14.13 et seq. The memorandum reflected: In addition, the ACT requires facilities to not have the temperature in areas used by residents fall below 65 degrees Fahrenheit .Where the Centers for Medicare and Medicaid Services (CMS) has a temperature range set by regulation that differs from the standards set in the Act, a nursing (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	home.licensed by the Department of Health may follow the temperature levels set by CMS . 2. On 1/23/26 at 8:47 AM, Surveyor #2 (S #2) with Certified Nursing Aide #1 (CNA #1) went inside room [ROOM NUMBER] (R618) and observed there was a white pipe that was on the floor. CNA #1 stated that it was probably from the sink metal part cover of under. 3. On 1/23/26 at 8:40 AM, S #2 went to 6th floor unit and observed in the hallway, near room [ROOM NUMBER] (R611) a linen cart not fully covered. The top cover of the linen cart with whitish, blackish dried substances and with brownish stain on the side of cover. At that time, S #2 observed the Director of Recreation (DR) in the hallway. S #2 notified the DR of the above concerns with the linen cart, and she stated that the linen cart should not be left open. Certified Nursing Aide #2 (CNA #2), in the presence of the DR, informed S #2 that the white stain on top of the linen cart cover were from the soap that burst. 4. On 1/23/26 at 9:04 AM, S #2 with the 4th floor Registered Nurse/Unit Manager (RN/UM) went to room [ROOM NUMBER]W (R410W and both observed the privacy curtain was hanging and not properly hooked on the rods. The RN/UM stated that she would ask someone to fix it. On 1/23/26 at 9:12 AM, S #2 and the RN/UM went to room [ROOM NUMBER]D (R424D), and both observed the privacy curtain was hanging and not properly hooked on the rods. S #2 also observed the ceiling vent with accumulation of grayish substances, that was upon entry to R424. 5. On 1/28/26 at 12:20 PM, S #2, LNHA, AIT, and Maintenance Director went to the 3rd floor. S #2 asked the Maintenance Director to check the temp inside the 3rd floor dining room, and it was 64 degrees. The 3rd floor dining room and hallway was cold. The Maintenance Director acknowledged that the dining room and the hallway were considered common areas for the residents, and temp should be between 68 to 81 degrees. On 1/28/26 at 1:47 PM, the survey team met with the LNHA and DON, and S #2 notified them of the above findings and concerns with R618, R410D, and R424D. S #2 also notified the LNHA and DON of the laundry room concerns and temperature concern in the 3rd floor areas. On 1/29/26 at 11:43 AM, the survey team met with the LNHA and DON. The surveyor then asked if residents should have homelike environment as part of requirement, and the LNHA responded yes. On that same date and time, the LNHA informed the surveyors that the heating guidance for temp of the building should not exceed 81 degrees and not below 65 degrees. S #2 then notified the LNHA again of the concern that on 1/27/26, the temperature in the 3rd floor dining room was 64 degrees. 6. On 1/22/26 at 10:35 AM, Surveyor #3 (S #3) observed on the 5th floor between Rooms 524-526, the rug on the hallway stained with large, dark, brownish substance, handrails scuffed and with wear, and wall stained with brown substances. S #3 observed by room [ROOM NUMBER] (R523) hallway with the wallpaper peeling. S #3 observed 5th floor hallways throughout some areas with dark stains on the rug, including the rug around the nursing station. S #3 observed the rug and walls around Rooms 505-507 stained throughout some spots. S #3 observed the 5th floor dining room area with peeling wallpaper. On 1/22/26 at 10:53 AM, S #3 in the presence of the 5th floor RN/UM observed the stained rugs and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	walls and she confirmed that she addressed the concerns with the LNHA, Maintenance Director, and DON every time I get a new patient, I verbally expressed my dilemma in the morning meeting, and it had been like that over a year, no matter how much they shampoo it did not come off. The RN/UM further stated They tell me they know. On 1/22/26 at 11:09 AM, S #3 interviewed the Housekeeping Director/ Maintenance Director, and she stated that the rugs were [AGE] years old, even it was shampooed every two weeks, the floor stains did not come out. She further stated I have to look at the peeled wallpaper. If we use bleach, it gets worse. I've been asking them to change the wallpaper. On 1/22/26 at 11:55 AM, S #3 observed the 6th floor main dining room with peeled wallpaper on the ceiling near the television and the walls. S #3 observed the rug area by the windows on the right side, stained with brownish substance. On 1/28/26 at 2:44 PM, the survey team met with the LNHA and the DON, and S #3 notified them of the above concerns regarding the environment. A review of the facility's Safe and Homelike Environment Policy, that was provided by the LNHA, with a reviewed date of 9/1/25, revealed under policy, in accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment.This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. Under definitions: Comfortable and safe temp levels means that the ambient temp should be in a relatively narrow range that minimizes residents' susceptibility to loss of body h eat and risk of hypothermia/hyperthermia and is comfortable for the residents. 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. Sanitary includes, but is not limited to, preventing the spread of disease-causing organisms by keeping resident care equipment clean and properly stored. Resident care equipment includes, but is not limited to, equipment used in completion of the activities of daily living. On 1/29/26 at 1:50 PM, the survey team met with the LNHA, DON and [NAME] President of Clinical Services (VPoCS) for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-31.2(e); 31.4(a)(b)(e)(f)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** REPEAT DEFICIENCYBased on observation, interview, and review of other pertinent facility documentation, it was determined that the facility failed to; a.) follow appropriate hand hygiene with regard to accessibility and availability of soap, for 1 of 5 resident rooms (room [ROOM NUMBER]) observed during tour, b.) ensure proper storage of linen supplies for 3 of 6 linen carts (4th and 6th floors and clean laundry room), c.) maintain cleanliness of the laundry room for 2 of 2 rooms (clean and dirty laundry rooms), d.) ensure the proper use of disinfecting wipes, and e.) follow appropriate infection control and sanitary practices for while donning and doffing personal protective equipment (PPE) for 2 of 2 nurses observed during the medication pass (med pass), in accordance with the Center for Disease Control and Prevention (CDC) guidelines, standards of clinical practice, and the facility's policy. This deficient practice was evidenced by the following: According to the CDC Clinical Safety: Hand Hygiene for Healthcare Workers, February 27, 2024, Hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning your hands with: Handwashing with water and soap (e.g., plain soap or with an antiseptic). According to CDC Appendix D - Linen and laundry management Best Practices for Environmental Cleaning in Global Healthcare Facilities with Limited Resources, Best Practices for Environmental Cleaning in Global Healthcare Setting, March 19, 2024. The Best practices for management of clean linen: Sort, package, transport, and store clean linens in a manner that prevents risk of contamination by dust, debris, soiled linens or other soiled items. Each floor/ward should have a designated room for sorting and storing clean linens. Transport clean linens to patient care areas on designated carts or within designated containers that are regularly (e.g., at least once daily) cleaned with a neutral detergent and warm water solution. 1.On 1/22/26 at 8:58 AM, Surveyor #1 (S #1) observed room [ROOM NUMBER]'s toilet room with no soap in the dispenser. On 1/23/26 at 8:24 AM, S #1 asked Registered Nurse (RN) to accompany S #1 inside R303, the resident was inside the room at that time. Both S #1 and the RN observed R303's toilet room with empty soap dispenser. S #1 also notified the RN of the concern that was observed yesterday (1/22/26) at 8:58 AM. The RN informed S #1 it was the responsibility of the housekeeper to put soap and acknowledged that staff use the sink for handwashing and there should be soap in the dispenser. She further stated that she would notify the Housekeeper (HK). On 1/23/26 at 8:35 AM, S #1 interviewed the HK, who informed S #1 that he was responsible for putting soap in the resident's room. S #1 notified the concern about R303 with no soap for two days, and he did not respond. 2. On 1/23/26 at 8:40 AM, S #1 went to 6th floor unit, observed in the hallway, near room [ROOM NUMBER] a linen cart was not fully covered, with clean linen supplies inside. S #1 observed the top cover with whitish, blackish dried substances, and the side of the cover with brownish stain. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that time, S #1 observed the Director of Recreation (DR) in the hallway. S #1 asked the DR about the linen cart and notified the concern about leaving open and asked what those stains were. The DR stated she was unsure what those stains were, and she stated that the linen cart should not be left open. Certified Nursing Aide #1 (CNA #1) came and informed S #1 and the DR that the white stain on top of the linen cart cover were from soap that burst. On 1/23/26 at 9:10 AM, S #1 with RN/Unit Manager (RN/UM) both observed the 4th floor linen cart cover had whitish substance stained on top of the cover, and as per CNA #2, who was at that time getting something from the linen cart stated that they did not know what the white on the linen cart cover was. 3. On 1/28/26 at 8:20 AM, S #1 went to the laundry room and toured with Laundry Staff (LS). The LS informed S #1 that the 1st room was considered the clean laundry room where the linen supplies and residents' clothes were dried, folded and stored in the four linen carts to be delivered later for 3 PM-11 PM shift. Both S #1 and the LS observed the big stand fan blowing air towards the clean linen supplies that were about to be folded and towards the table where there were folded linen supplies. The big stand fan with accumulation of grayish substances which the LS confirmed were accumulation of dust and should have been cleaned. The floor was observed with dust. At that same time, there were four linen carts, the 2nd linen cart was observed with papers and plastics on the bottom shelf, and there were clean linen supplies inside the cart. On that same date and time, both S #1 and the LS observed the next room, which the LS stated considered the dirty area of the laundry room where the linen supplies were being washed. There was an accumulation of grayish substances on the floor, walls, and washers. The LS confirmed they were accumulation of dust and should have been cleaned. The LS also stated that there was no accountability log for cleaning the laundry rooms. On 1/28/26 at 12:35 PM, S #1 interviewed the Infection Preventionist Nurse (IPN), who informed S #1 that she was responsible for service and competencies for all staff with regard to infection control and she does rounds daily in the residents' units, of resident's common area, rooms, and laundry. S #1 asked the IPN as to why it was important to ensure that there was soap in the dispenser inside the resident's room and toilet room, and the IPN responded that staff to wash hands properly and soap was needed. S #1 notified the concern with R303 with no soap for two days of observation. On that same date and time, S #1 notified the IPN of the concern in the laundry about the fan blowing air directly to clean uncovered linens supplies, the IPN stated the fan should be clean up. S #1 also notified the concern with linen carts in the laundry area with plastic and paper on the bottom of the linen cart with clean supplies and on 4th and 6th floors with stains on their linen cart covers and was left open. The IPN stated that we always clean the linen carts, it should be clean. On 1/28/26 at 1:47 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. A review of the facility's Laundry Policy that was provided by the LNHA, with a reviewed/revised date of 9/1/25, revealed, the facility launders linens and clothing in accordance with current CDC guidelines to prevent transmission of pathogens.Policy Explanation and Compliance Guidelines:.6. If using fans in laundry processing areas, prevent cross-contamination of clean linens from air blowing from soiled processing areas. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/29/26 at 11:43 AM, the survey team met with the LNHA and DON. The LNHA stated that there was no additional information to provide. 4. On 1/23/26 at 8:44 AM, Surveyor #2 (S #2) observed the Licensed Practical Nurse #1 (LPN #1) on the 6th floor for med pass. S #2 observed LPN #1 donned (put) PPE, gloves and a gown, to enter a resident's room to administer medications (meds). S #2 observed a signage outside of the room reflected that the resident had Enhanced Barrier Precautions (EBP; an infection control strategy for nursing homes, requiring gown and glove use during high-contact resident care). S #2 observed LPN #1 administer meds, remove (doffed off) the gown and gloves into a receptacle then proceeded to the med cart. S #2 did not observe LPN #1 perform hand hygiene after removal of PPE. On the same date, between the times of 9:05 AM and 10:10 AM, S #2 observed LPN #2 on the 4th floor for med pass. S #2 observed LPN #2 performed the following tasks while administering meds to several residents who had EBP signage outside of their rooms. S #2 observed LPN #2 donned and and doffed off PPE after cleaning the cuff of the facility electronic blood pressure machine (BP cuff) and not perform any hand hygiene. S #2 observed LPN #2 changed gloves several times after leaving a resident's room and in between cleaning the BP cuff and not perform hand hygiene. S #2 observed LPN #2 cleaned the BP cuff with a cleaning wipe obtained from a purple top container and not waited the required contact time of two minutes as reflected on the front label of the container before using the BP cuff on the next resident. S #2 observed LPN#2 cleaned the BP cuff right before using on a resident and observed LPN #2 cleaned the BP cuff right after another resident. On 1/28/26 at 12:47 PM, S #2 interviewed the IPN and asked the IPN if the staff was provided with education on infection control procedures, including but not limited to use of PPE, hand sanitizing procedures, and cleaning of medical equipment. The IPN stated yes, the staff were made aware via education of these policies and procedures. S #2 asked what was expected for a staff member who was entering a room marked EBP but not having direct care. The IPN stated the staff would be expected to sanitize hands by washing or alcohol gel before and after, PPE was only needed for direct care. The IPN further stated hand sanitizing before and after. At that same time, S #2 asked what the procedure was with used for cleaning medical equipment. The IPN stated that the purple top wipes should be used, with gloves, the staff should wait at least two minutes before using again per the product instructions. She also stated that the staff should follow hand sanitizing when removing gloves after cleaning. The IPN added that the equipment should be sanitized after use and before moving on to the next resident and if the staff was using equipment and they were unsure it had been cleaned, they should clean it. On 1/28/26 at 1:47 PM, the survey team met with the LNHA and DON, and S #2 notified them of the above findings and concerns during medpass. On 1/29/26 at 11:44 AM, the survey team met with the LNHA and DON for responses to concerns. The DON stated that the nurses in question may have been nervous during the observation. The DON also stated that an educational in-service was done for the whole building on 1/28/26. A review of the facility's Hand Hygiene Policy that was provided by the LNHA, with a reviewed/revised date of 9/1/25, revealed, all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.Hand hygiene is a general term for cleaning hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR).Policy Explanation and Compliance Guidelines: 5. Hand (continued on next page)

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	315460	A. Building B. Wing	01/29/2026

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hygiene technique when using soap and water: a. Wet hands with water.b. Apply to hands the amount of soap recommended by the manufacturer.6.a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. The policy also revealed a Hand Hygiene Table. The table reflected a box checked to use either soap and water or alcohol-based hand rub (preferred) next to Before applying and after removing PPE, including gloves. A review of the facility's Cleaning and Disinfection of Resident-Care Equipment Policy, with last reviewed/revised date of 9/1/25, the policy reflected under 3.b. Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident. 3.j. Follow manufacturer recommendations for cleaning equipment. A review of the facility's Personal Protective Equipment Policy, last reviewed/revised date of 9/1/25, the policy reflected, under 5.b.Perform hand hygiene after removing gown. The LNHA did not provide any further pertinent information. NJAC 8:39-19.4 (a)1., (l); 19.4(a)(2)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to ensure as needed psychotropic medication ordered was limited to 14 days, unless the attending physician/prescribing practitioner documents a rationale to extend the medication for 1 of 5 residents reviewed for unnecessary medications (Residents #12). This deficient practice was evidenced by the following:On 1/21/26 at 10:44 AM, the surveyor observed Resident #12 lying asleep in bed. A review of Resident #12's admission Record (admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, hemiplegia, and hemiparesis and hypertension. A review of Resident #12's most recent Annual Minimum Data Set (MDS) reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident's cognition was moderately impaired. A review of Resident #12's January electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) included the following orders:Lorazepam Oral Concentrate 2MG/ML (milligrams/milliliters) give 0.25 ml by mouth every 4 hours as needed (PRN) for anxiety and restlessness with an order date of 1/16/26.The order was not limited to 14 days. A review of Resident #12's Progress Notes did not include any documentation from the attending physician/prescribing practitioner, a rationale to extend the medication (med). On 1/23/26 at 12:23 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that when a resident received hospice services there was an order for lorazepam PRN but was not sure if it required a 14 day stop to be reevaluated if a resident needed it. On 1/27/26 at 11:26 AM, the surveyor interviewed the Sixth Floor Unit Manager (SFUM) who stated that the lorazepam order for Resident #12 should have had a stop date. On 1/27/26 at 1:55 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that Resident #12's lorazepam order was not limited to 14 days and that there was no documentation of a rationale to extend the med. On 1/28/26 at 1:50 PM, the surveyor met with the LNHA and DON to provide an opportunity for a response for the concern. The LNHA did not provide any additional information. N.J.A.C. 8:39-27.1

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to complete the Minimum Data Set Assessment (MDS), an assessment tool used to facilitate the management of care, within fourteen days as required, for 2 of 31 residents, (Residents #51 and #94), reviewed for MDS, in accordance with federal guidelines. This deficient practice was evidenced by the following:The surveyor reviewed the medical records of the following residents and their MDS and revealed:1. On 1/27/26 at 1:35 PM, the surveyor reviewed Resident #51's comprehensive admission MDS dated [DATE], which revealed it was completed late on 1/22/26 (3 days late). The resident had an Entry MDS which was dated 1/6/26. 2. On 1/27/26 at 1:38 PM, the surveyor reviewed Resident #94's comprehensive admission MDS dated [DATE], which revealed it was completed late on 1/2/26 (8 days late). The resident had an Entry MDS which was dated 12/12/25. On 1/28/26 at 11:38 AM, the surveyor interviewed the MDS Director (MDSD) who stated that she was responsible for MDS assessments, We try to do the assessments as they are due. The MDSD further stated that We follow the Resident Assessment Instrument (RAI-a comprehensive assessment and care plan process). The surveyor asked when the admission MDS should be completed. The MDS Coordinator replied that the assessment and the Care Areas (CAAS) need to be completed on the 14th day from admission. The surveyor and the MDS Coordinator reviewed Resident #51's and Resident #94's comprehensive MDSs and the MDSD confirmed regarding Resident #51's Section F-activities was done late. She also stated that it should have been completed it on time. At that same time, the MDSD stated for Resident #94, It was the Care Areas that were late, it should have been completed earlier. The surveyor requested validation reports (CMS Submission Report) for the two comprehensive MDS assessments. On 1/28/26 at 2:00 PM, the License Nursing Home Assessments (LNHA) provided the validation reports (CMS report) which confirmed Resident #51's admission MDS assessment dated [DATE] was completed late including the Care Areas/Care Plan. Resident #94's admission MDS dated [DATE] also reflected as completed late due to the Care Areas/Care Plan not being completed timely. On 1/28/26 at 2:32 PM, the survey team met with the LNHA and the Director of Nursing (DON) and the surveyor notified them of the concern with late MDSs completion. On 1/29/26 at 11:45 AM, the LNHA did not provide additional information. A review of the facility's MDS 3.0 Completion Policy dated 9/1/25, revealed under Policy Explanation and Compliance Guidelines 2b, admission Assessment-completed within 14 days of admission counting the day of admission as day #1. NJAC 8:39-11.1, 11.2(e)

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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	Ensure each resident receives an accurate assessment. Based on interview and record review, it was determined that the facility failed to accurately reflect the resident status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care in accordance with the federal guidelines for 2 of 31 residents (Residents #3 and #67) reviewed for the accuracy of MDS coding.This deficient practice was evidenced by the following: A review of the Centers for Medicare & Medicaid Services (CMS's) Resident Assessment Instrument (RAI; helps facility staff to gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan) Version 3.0 Manual, October 2025, reflected under Section M Skin Conditions, Steps for Assessment 1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer/injury risk assessments. 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. 3. Examine the resident and determine whether any ulcers, injuries, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer/injury development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g., elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing). 1.Surveyor #1 (S #1) reviewed the electronic medical record (EMR) of Resident #3. A review of the admission Record (AR; admission summary) reflected that Resident #3 was admitted to the facility with diagnoses that included but were not limited to osteomyelitis (a severe bone infection, usually bacterial) and Rhett's Syndrome (a rare, severe neurodevelopmental disorder resulting in loss of speech, seizures and motor skills.) A review of the quarterly MDS with an assessment reference date (ARD) of 11/21/25, revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 99, which reflected that Resident #3's cognition was unable to be assessed as the resident could not complete the interview. Section H, Bowel and Bladder, revealed H0100 Appliances A that the resident was assessed as having an indwelling catheter, (a tube leading from the bladder to a collection device used to facilitate passage of urine). H0300 Urinary Continence indicated 9, not rated, as the resident was assessed as having a catheter. A review of the resident's Progress Notes (PN) revealed a Physician's Note on 10/31/25, reflected, Pt (patient) was seen and examined for follow up. Pt saw Urology. Foley was removed and pt urinated comfortably. The PN also revealed a General Note on 10/31/25, reflected a Note Text: received resident in bed alert but non verbal. resident voiding freely catheter removed no complications noted. v/s (vital signs) stable no s/s (signs/symptoms) of pain or distress. Entered by a Licensed Practical Nurse (LPN). A review of the resident's Comprehensive Care Plan (CCP) dated 11/22/25, did not reflect that the resident had a catheter, a catheter was removed, or that the resident was incontinent of urine. On 1/22/26 at 11:50 AM, S #1 interviewed the Registered Nurse (RN) on the floor where Resident #3 resides. The RN stated that the foley catheter was removed about two months ago due to leaking and now the resident voids and was incontinent. On 1/23/26, S #1 asked the Licensed Nursing Home Administrator (LNHA) if the facility had a policy (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for MDS accuracy. The LNHA stated that the facility followed the Resident Assessment Instrument (RAI) manual. On 1/28/26 at 1:47 PM, the survey team met with the LNHA and Director of Nursing (DON), and S #1 notified the DON of the concern with the accuracy of Resident #3's MDS. On 1/29/26 at 11:44 AM, the survey team met with the LNHA and DON for responses to concerns. The provided a CCP for Resident #3 that included a focus reflecting that the resident had bowel and bladder incontinence, dated 1/28/26, after surveyor inquiry. The LNHA did not provide any further pertinent information. 2. On 1/22/26 at 10:54 AM, Surveyor #2 (S #2) interviewed the MDS Director (MDSD) and MDS Coordinator #1 (MDSC #1) regarding MDS. The MDSD informed S #2 that both of them (MDSC #1) shared responsibilities with MDS and that they follow RAI Manual when doing MDS that included assessment, scheduling, completing and transmitting MDS. S #2 reviewed the medical records of Resident #67, and revealed: A review of the AR or face sheet revealed that Resident #67 was admitted to the facility with diagnoses that included but were not limited to; encounter for surgical aftercare following surgery on the circulatory system, type 1 diabetes mellitus without complications, difficulty in walking, not elsewhere classified, heart failure unspecified, and essential hypertension (elevated blood pressure). A review of the most recent comprehensive MDS, with an ARD of 8/27/25, reflected that Resident #67 had a BIMS score of 14 out of 15, indicated intact cognition. Section J Health Conditions, reflected that the resident's pain assessment was signed off as completed on 8/28/25 at 8:07 PM by MDSC #2. Section M Skin Conditions revealed that Resident #67 had unhealed stage 2 pressure ulcer. A review of the active CCP did not reflect that the resident had an unhealed pressure ulcer. A review of the Weekly Skin Review dated 8/26/25, revealed, Resident #67 had three surgical wounds. The surgical wounds were located in the midchest, epigastric, and left medial shin. There was no documented evidence that the resident had unhealed pressure ulcers. A review of the August 2025 electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) revealed the order for wound treatment to sacrum stage 2 was discontinued (d/c) on 8/22/25. There were orders for wound treatment to mid abdomen, mid chest, and lateral leg surgical wounds. On 1/27/26 at 12:52 PM, S #2 interviewed the MDSD in the presence of MDSC #1 regarding MDS of Resident #67 for ARD 8/27/25. The MDSD informed S #2 that MDSC #2 was their previous remote MDS staff. She also stated that MDSC #2 worked 100% remote when doing MDS. She also stated that the pain assessment in the MDS should be done within ARD and not after the ARD. The MDSD stated that the MDS responses to Section J were auto populated responses from previous assessment. The MDSD also confirmed and stated that the MDS should reflect the resident's current condition at that time period of assessment or ARD. At that same time, S #2 notified the MDSD and MDSC #1 of the above concerns that Resident #67's ARD of 8/27/25 Section J's assessment was done on 8/28/26 at 8:08 PM, and the Section M was (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	coded had stage 2 pressure ulcer when the resident's weekly skin assessment on 8/26/25 did not reflect pressure ulcer except for surgical wounds. S #2 also notified the MDSD and MDSC #1 that there was no care plan for stage 2, the eMAR and eTAR revealed on August 2025 stage 2 sacrum treatment order was d/c on 8/22/25. The MDSD had no respond when asked why the MDS ARD 8/27/25 did not reflect the current condition of resident's wound at that time and interview for pain assessment was done after the ARD. On 1/27/26 at 2:38 PM, the LNHA stated that the facility did not have a policy with regard to accuracy of MDS, the facility followed the RAI Manual. On 1/28/26 at 9:02 AM, S #2 called and interviewed MDSC #2 regarding Resident #67's MDS. MDSC #2 informed S#2 that the reason she electronically signed Section J after the ARD on 8/27/25, because MDS to be done after the ARD and that she used the auto populated responses from the electronic medical record which was done on 8/25/25. S #2 then asked MDSC #2, if she did use the auto populated responses from the 8/25/25 pain assessment, why the responses were not exactly the same and some were changed, and she did not respond. On that same date and time, S #2 asked MDSC #2 as to why Section M was coded with stage 2 unhealed pressure ulcer if there were no treatment orders and no CP, and she responded that she would get back to S #2. She confirmed that she utilized medical records of residents when doing MDS and she did not interview residents or staff because she was a remote MDS worker and not physically present at the facility. On 1/28/26 at 10:14 AM, S #2 interviewed the DON and confirmed that there were no other paper documents or medical records for residents because everything was uploaded in the electronic medical record. The DON also stated that it was expected for the nurse to obtain an order for wound treatment if there was a wound. The DON informed S #2 that the facility follow the RAI manual. S #2 notified the above concern with Section J and M of Resident #67's MDS, and the DON stated that MDSC #2 should have followed the pain assessment on 8/25/25 because they were not here to interview the resident and just helping. At that same time, S #2 notified the DON of the concern with section M, and the DON stated that Resident #67 had no pressure ulcer because it was resolved. The DON acknowledged that the 8/27/25 MDS was inaccurate because the resident had no unhealed pressure ulcer. On 1/28/26 at 12:59 PM, the DON provided a copy of the resident's order audit report which showed that the resident's wound was healed. The DON stated that there was a problem in accuracy of MDS because the resident had no wounds and it was an error from the nurse part when the nurse documented there was a stage 2 sacrum. On 1/28/26 at 1:47 PM, the survey team met with the LNHA and DON, and S #2 notified them of the above findings and concerns with Resident #67's MDS. On 1/29/26 at 11:43 AM, the survey team met with the LNHA and DON. The LNHA stated that there was an accuracy problem with MDS of Resident #67. On 1/29/26 at 1:50 PM, the survey team met with the LNHA, DON and [NAME] President of Clinical Services for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-33.2(a)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview and record review, it was determined that the facility failed to update and revise the comprehensive care plan of a resident. This deficient practice was identified for 1 of 31 residents (Resident #3), reviewed for bladder incontinence.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. The surveyor reviewed the electronic medical record (EMR) of Resident #3. A review of the admission Record (admission summary) reflected that Resident #3 was admitted to the facility with diagnoses that included but were not limited to osteomyelitis (a severe bone infection, usually bacterial) and Rhett's Syndrome (a rare, severe neurodevelopmental disorder resulting in loss of speech, seizures and motor skills.) A review of the quarterly Minimum Data Set (MDS) with an assessment reference date (ARD) of 11/21/25, revealed in Section C, a Brief Interview for Mental Status (BIMS) score of 99, which reflected that Resident #3's cognition was unable to be assessed as the resident could not complete the interview. Section H, Bowel and Bladder, revealed H0100 Appliances A that the resident was assessed as having an indwelling catheter. H0300 Urinary Continence indicated 9, not rated, as the resident was assessed as having a catheter. A review of the resident's Progress Notes (PN) revealed a Physician's Note dated 10/31/25, reflected that the resident was seen and examined for follow up urology consult, Foley's was removed and the resident urinated comfortably. The PN also revealed a General Note dated 10/31/25, reflected a Note Text that the resident was received in bed alert but non verbal, resident voiding freely catheter removed no complications noted, that was electronically signed by a Licensed Practical Nurse (LPN). A review of the resident's Comprehensive Care Plan (CCP) dated 11/22/25, did not reflect that the resident had a catheter, a catheter was removed, or that the resident was incontinent of urine. On 1/22/26 at 11:50 AM, the surveyor interviewed the Registered Nurse (RN) on the floor where Resident #3 resides. The surveyor asked the RN about Resident #3's incontinence status. The RN stated that the foley catheter was removed about two months ago due to leaking and now the resident voids and is incontinent. On 1/28/26 at 1:47 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified the concern that the CCP did not reflect that the foley catheter was discontinued to reflect the current condition of the resident. The surveyor asked the DON if the CCP should include documentation if the resident was incontinent. On 1/29/26 at 11:44 AM, the survey team met with the LNHA and DON for responses to concerns. The facility provided a CCP for Resident #3 that included a focus reflecting that the resident has bowel and bladder incontinence, dated 1/28/26, after surveyor's inquiry. The LNHA did not provide any further pertinent information. NJAC 8:39-11.1, 11.2(h)(i)

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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. Based on observation, interview, record review, and review of other pertinent facility provided documentation, it was determined that the facility failed to a.) follow a physician's order for side effect monitoring and clarify a physician's order for a hypoglycemic episode for 2 of 28 residents reviewed (Resident #7 and Resident #12) and b.) follow appropriate tuberculosis (TB) testing and documentation for 1 of 31 residents, Resident #51, according to the standard of clinical practice and facility's policies.This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 a 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 with in 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 1/21/26 at 11:12 AM, Surveyor #1 (S #1) observed Resident #7 sleeping in bed. A review of Resident #7'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; fracture of left femur, dementia and hypertension. A review of Resident #7's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision making were severely impaired. A review of Resident #7's January electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) included the following orders: A) Anticoagulant Medication (med) Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, N&V (nausea & vomitting), diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or V/S (vital signs), SOB (shortness of breath), nose bleeds-document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes' and progress note (PN) findings. every shift. Further review included that nurses signed Y for monitored and none observed and other nurses signed N but did not indicate in the PN what the side effect was that was observed as indicated in the order. B) IF RESIDENT IS NOT ALERT/NOT ABLE TO SWALLOW as needed for HYPOGLYCEMIC EPISODE Give meal or snack within 1 hour. The order was not clarified with the physician since a meal or snack would not be able to be given to a resident that was not alert or not able to swallow. On 1/28/26 at 2:27 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and Director (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Nursing (DON) the concerns regarding Resident #7's side effect monitoring for anticoagulant order which was not followed and the hypoglycemia order that was not clarified. On 1/29/26 at 11:43 AM, in the presence of the LNHA, the DON stated that she in serviced staff regarding the y and the n, and supporting documentation for side effects. 2. On 1/21/26 at 10:44 AM, S #1 observed Resident #12 lying asleep in bed. A review of Resident #12's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, hemiplegia and hemiparesis, and hypertension. A review of Resident #12's most recent comprehensive MDS reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident's cognition was moderately impaired. A review of Resident #12's January eMAR and eTAR included the following orders: A) Anticoagulant Med Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, N&V, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or V/S, SOB, nose bleeds-document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes' and PN findings. check Last INR (stands for International Normalized Ratio, a standardized measure of how long it takes blood to clot) result every shift with an order date of 01/05/2026. Review of the MAR indicated INR and the nurses documented No or NA or Y in the row for INR. Anticonvulsant Med Use -Observe resident closely for significant side effects: Drowsiness, Ataxia(drunk walk), Nystagmus, Dizziness, Blurred Vision, Nausea, Rash, Gum Enlargement, Jaundice. – Special Attention: In use with other CNS (Central Nervous System) depressant drug or resident who develop fever blood dyscrasias. Document: 'Y' if monitored and none of the above observed. 'N' if monitored and any of the above was observed, select chart code 'Other/ See Nurses Notes' and progress note findings every shift with an order date of 1/5/26. The nurses documented a check mark in the eMAR. The nurses did not document a Y or N as indicated in the order. Anti-Depressant Med Use -Observe resident closely for significant side effects: Common - Sedation, Drowsiness, Dry Mouth, Blurred Vision, Urinary Retention, Tachycardia, Muscle Tremor, Agitation, Headache, Skin Rash, Photosensitivity(skin), Excess Weight Gain. - Special Attention For: Heart Disease, Glaucoma, Chronic Constipation, Seizure Disorder, Edema. every shift with an order date of 1/5/26. The order did not contain how to document if a significant side effect (s/e) was observed. Anti-Psychotic Med Use -Observe resident closely for significant s/e: Common -Sedation, Drowsiness, Dry Mouth, Constipation, Blurred Vision, Extra Pyramidal Reaction, Weight Gain, Edema, Postural Hypotension, Sweating, Loss of Appetite, Urinary Retention.- Special Attention For: Tardive Dyskinesia, Seizure Disorder, Chronic Constipation, Glaucoma, Diabetes, Skin Pigmentation, Jaundice. every shift with an order date of 1/5/26. The order did not contain how to document if a significant s/e was observed. A review of Resident #12's PN did not include any documentation of what s/e was observed for any of the documented N's in the January eMAR and eTAR. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B) IF RESIDENT IS NOT ALERT/NOT ABLE TO SWALLOW as needed for HYPOGLYCEMIC EPISODE Give meal or snack within 1 hour. The order was not clarified with the physician since a meal or snack would not be able to be given to a resident that was not alert or not able to swallow. On 1/23/26 at 12:23 PM, S #1 interviewed Licensed Practical Nurse #1 (LPN #1) who stated that for s/e monitoring there was an order in the computer and that if one of the listed s/e were observed there should be a PN. LPN #1 stated that there were different orders for hypoglycemia when a resident was alert and when a resident was not alert. LPN #1 stated that Resident #12's hypoglycemic episode when not alert was not correct and that she thought it was a typo mistake. On 1/27/26 at 11:26 AM, S #1 interviewed the 6th floor Unit Registered Nurse/Unit Manager #1 (RN/UM #1) who stated that the nurses understand differently the s/e monitoring order and that some say yes it was observed, and some say no. RN/UM #1 stated that there should be a standard one. RN/UM #1 stated that for the hypoglycemic episode give a meal would be for a resident that was alert. On 1/27/26 at 1:55 PM, S #1 notified the LNHA and DON the concerns that Resident #12's s/e monitoring for several medications (meds) were not standard with the same legend with yes or no and that when a nurse indicated there was a s/e observed that the nurse did not indicate what the s/e was that was observed in the PN; and the hypoglycemic episode order was not clarified. On 1/28/26 at 1:50 PM, in the presence of the LNHA, the DON stated that Resident #12's hypoglycemic episode order was from a template in the computer and that it should have been clarified. The DON stated that she in-serviced nurses to be more specific to documentation of s/e monitoring. A review of the facility's Provision of Physician Ordered Services Policy with a reviewed/revised date of 9/1/25, included the following: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. A review of the facility's Medication Monitoring/Side Effects Policy with a reviewed/revised date of 9/1/25, included the following: This facility takes a collaborative, systematic approach to med management, including the monitoring of meds for efficacy and adverse consequences.4. Licensed nurses, with periodic oversight by nurse managers, shall:.b. Adhere to facility policies and current standards of practice for administration and monitoring of medications.e. Perform routine medication reconciliations to verify accuracy of medication orders. 3. On 1/21/26 at 11:17 AM, Surveyor #2 (S #2) observed the Resident #51 sitting in a wheelchair, not able to answer questions. A review of the AR which revealed diagnoses that included but not limited to; acute respiratory failure with hypoxia, encephalopathy (dysfunction of the brain that alters its function), and chronic diastolic congestive heart failure (heart cannot pump enough blood causing fluid to back up). A review of the comprehensive MDS, with an ARD of 1/13/26, reflected BIMS score of 3 out of 15 indicating severe cognitive impairment. A review of the physician's order (PO) dated 1/6/26, Tuberculin PPD (Purified Protein Derivative, (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which is a key component used in the TB skin test to determine if a person has been infected with Tuberculosis bacteria) Solution 5 UNIT/0.1milliliter (ml). Inject 0.1 ml intradermally (ID) everyday shift for TB Screening for 1 administration until finished Step 1-Administer 0.1ml; A PO dated 1/6/26, Tuberculin PPD Solution. Step 2-Administer 0.1 tuberculin units 14 days after 1st dose administration. Administer only if 1st dose administration with a negative result. A review of the January 2026 eMAR of the above PPD order entry dated 1/6/26, revealed the entry was given twice signed by two different nurses to indicate the PPD solution was administered to Resident #51 on 1/6/26 by LPN #2 and 1/7/26 by LPN#3. The PPD results were read by LPN #2 on 1/8/26 and 1/9/26, indicating negative results. On 1/23/26 at 10:50 AM, S #2 reviewed with the 5th floor Registered Nurse/Unit Manager #2 (RN/UM #2) regarding the concern on the eMAR the double administration of PPD given on 1/6/26 and 1/7/26. UM/RN #2 stated, The PPD looks like it was given twice, and she did not know what happened, and she would look into it. A review of the PN revealed there was no documented evidence to indicate if the PPD solution was administered or not administered to Resident #51 on 1/7/26. On 1/27/26 at 12:07 PM, S #2 interviewed LPN#2 with regard to facility's process for PPD administration for new admissions and she stated that We have to check the PO for PPD and administer upon admission, read after 72 hours, if negative, document it, and administer the 2nd dose of PPD in 14 days. LPN #2 further stated that she did not know why the PPD was administered twice. The LPN#2 confirmed it should have been given one time on admission on ly. On 1/27/26 at 12:15 PM, S #2 interviewed RN/UM #2 who stated the DON had spoken with LPN #3 and got a statement that it was a mistake on LPN #3's part. RN/UM #2 confirmed that it was after surveyor's inquiry. RN/UM #2 also stated that it was supposed to be documented if there was a mistaken entry. On 1/27/26 at 12:56 PM, the DON stated that LPN#3 informed the DON that he never administered the PPD (the duplicate), and for some reason it popped up in the eMAR. The DON further stated, We had a glitch of the computers at that time. The DON confirmed that there was no documented evidence that the duplicate PPD was an error and there was a computer error not until after surveyor's inquiry. On 1/28/26 at 2:36 PM, the survey team met with the LNHA and the DON, and S #2 notified them of the above findings and concerns with regard to PPD. On 1/29/26 at 11:45 AM, the LNHA and DON did not provide additional information. A review of the facility's Administration and Interpretation of Tuberculin Skin Tests Policy dated 9/1/25, revealed under Policy Explanation and Compliance Guidelines #2, skin testing of residents will be in accordance with physician orders . A review of the facility's Provision of Physician Ordered Services Policy dated 9/1/25, revealed under Definition, Professional Standards of Quality means that care and all services are provided according to accepted standards of clinical practice . NJAC 8:39-11.2(b)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident receive treatment and care in accordance with professional standards of practice, by failing to ensure; a.) physicians' orders and approved plan of care were followed for 1 of 31 residents (Resident #120), b.) physician was notified of change in condition of 1 of 2 residents (Resident #120), and c.) recommendations were followed through and physician's orders were clarified for 1 of 2 residents, (Resident #12), reviewed for hospice. 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 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. 1.On [DATE] at 10:44 AM, Surveyor #1 (S #1) observed Resident #12 lying asleep in bed. A review of Resident #12's admission Record (AR; admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, hemiplegia and hemiparesis, and hypertension. A review of Resident #12's most recent comprehensive Minimum Data Set (MDS) reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident's cognition was moderately impaired. A review of Resident #12's hospice facility visit notes included the following: [DATE] Morphine 5 mg (milligram) q (every) 1 hr (hour) PRN (as needed) symptom management pain/dyspnea. [DATE] May give lorazepam for muscle spasms if baclofen is not effective. A review of Resident #12's January electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) included the following orders: Morphine Sulfate (Concentrate) Oral Solution 5 mg/0.25 mlm (milligram/milliliters) Give 0.25 ml by mouth q 1 hr PRN for symptom management, pain management. There was not a second order for Morphine Sulfate for dyspnea as recommended. There was no (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note (PN) to indicate that the physician did not agree with the recommendation. Further review of the eMAR and eTAR did not reflect an order for Lorazepam that had the indication for muscle spasms if bacloflen was not effective. There was no PN to indicate the physician did not agree with the recommendation. On [DATE] at 10:01 AM, S #1 interviewed the Registered Nurse (RN) who stated that Resident #12 received hospice services and that a hospice nurse would visit the resident and make recommendations for orders and that if the physician agreed with the recommendations, then the physician would write the order. On [DATE] at 12:23 PM, S #1 interviewed Licensed Practical Nurse #1 (LPN #1) who stated that if the physician did not agree with a hospice recommendation, then there should be PN that would have physician not in agreement with the recommendation. LPN #1 stated that there should be two different orders for morphine, one for pain and one for shortness of breath (SOB) (dyspnea). LPN #1 further stated that there should be a separate order for lorazepam that was recommended for muscle spasm. She added that there would be a PN if the physician did not agree with the recommendation. On [DATE] at 11:26 AM, S #1 interviewed the 6th floor Registered Nurse/Unit Manager (RN/UM) who stated that the physician usually agreed to the hospice recommendations and that if the physician did not agree then there should be a note. On [DATE] at 1:55 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that Resident #12's hospice recommendations were not followed for morphine for dyspnea and lorazepam for muscle spasm if baclofen was not effective. On [DATE] at 1:50 PM, in the presence of the LNHA, the DON stated that Resident #12's physician did not put a separate order for dyspnea based on the medical record and the resident's respiratory rate was stable. S #1 asked the DON if an order for morphine was for two different reasons should the order be separated. The DON stated that it would depend on the condition of the resident. 2. On [DATE] at 8:22 AM, Surveyor #2 (S #2) reviewed the closed medical records of Resident #120, 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; end stage renal disease, type 2 diabetes mellitus without complications, anxiety disorder unspecified, essential hypertension (elevated blood pressure), and anemia (low blood count) unspecified. A review of the most recent MDS revealed that the resident had expired. A review of the most recent quarterly MDS with an ARD [DATE], reflected on Section C Cognitive Patterns, a BIMS score of 15 out of 15, which reflected resident's cognition was intact. Section O - Special Treatments, Procedures, and Programs reflected that the resident received oxygen and was on dialysis. A review of the personalized Care Plan (CP), with a focus that Resident # 120 was on palliative care related to chronic disease that was initiated on [DATE] and revised on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the [DATE] orders, eMAR, and eTAR revealed a physician order (PO) for the following: - Fluid restriction as ordered: 7 AM – 3 PM shift: 600 ml (nursing: 400 ml; dietary: 0 ml) 3 PM – 11 PM shift: 200 ml (nursing: 300 ml; dietary: 0 ml) 11 PM – 7 AM shift: 200 ml (nursing: 300 ml; dietary: 0 ml) in the afternoon 3 PM – 11 PM shift: 200 ml (nursing: 300 ml; dietary: 0 ml)-Order date [DATE]-d/c (discontinue) date[DATE]. The above order was plotted every shift, there were no documented amount, and did not follow the PO. - Humalog solution 100 unit/ml, inject as per sliding scale: if 0 - 70 = 0 units call MD (Medical Doctor) if <70 and follow hypoglycemic protocol; 71 - 150 = 0 units; 151 - 200 = 4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 400 = 10 units greater than 401 = give 10 units and call MD, subcutaneously before meals for diabetes-Order date [DATE]-d/c date [DATE]. The eMAR showed on [DATE] at 4 PM, blood sugar (BS) was 69. There was no documented evidence that the MD was called or notified according to the PO above. -If Resident is alert and able to swallow. PRN for hypoglycemic episode give dextrose 40% gel (31 grams) or 4 oz (ounces) orange juice-Order date [DATE]-d/c date [DATE] The eMAR did not reflect that the order above for PRN dextrose 40% gel was administered for BS of 69 on [DATE]. - If Resident is alert and able to swallow. PRN for hypoglycemic episodes give meals or snacks within 1 hr. Order date [DATE]-d/c date [DATE]. The eMAR did not reflect that the order above for PRN to give meals or snacks within 1 hr was administered for BS of 69 on [DATE]. Further review of the eMAR revealed that there was no documented evidence that the BS was checked and followed the PO on [DATE] and [DATE]. A review of the PN with an effective date of [DATE] at 2:06 PM, that was electronically signed by LPN #2, Note Text: 0730 (7:30 AM) Resident BS checked and was 36. Glucagon 1 ml given, cup of orange juice. 0735 (7:35 AM) resident BS rechecked (36 mmol/l (stands for millimoles per liter, which is a unit of measurement used to express the concentration of a substance in a solution). Given another cup of orange juice and cup of milk. 0745 (7:45 AM) BS rechecked (101 mmol/l). 0805 (8:05 AM) BS checked (43mmol/l) 0840 (8:40 AM) Resident picked up by Medical Transport via stretchers for dialysis. Vital signs obtain prior and within normal limits. 11:30 (11:30 AM) Resident returned from dialysis(dialysis canceled due to low BP (blood pressure) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(midodrine given). Vitals signs obtained and within normal limits. Further review of the medical records revealed that there was no documented evidence that the physician (also known as the MD) was notified of the BS according to the PO and notified of the change in condition with regard to BS. There was no documented evidence that the PN interventions that were documented for glucagon, milk, and orange juice were signed off as given in the eMAR. On [DATE] at 8:35 AM, S #2 interviewed the DON, who informed S #2 that the facility's practice was to initiate an eInteract if there was a change in condition of a resident that included hypoglycemia or low BS and the resident was transferred to the hospital. She further stated that if the resident was not transferred to the hospital, the nurse would initiate the SBAR (stands for Situation, Background, Assessment, and Recommendation, and it is a structured communication tool used in nursing to enhance clarity and efficiency in conveying critical patient information) and document also in the PN. The DON also stated that SBAR is done if there was a change in resident for example if the resident would be needing an antibiotic or treatment. On that same date and time, the DON stated that if the resident had an order for hypoglycemic treatment in the eMAR, the nurse had to follow it and administer it according to the PO. The DON stated that the nurse had to document in the eInteract or PN, if they administered med, and to sign the eMAR. She further stated that the nurse had to call and notify the MD of the change in condition and document also in PN. At that time, S #2 notified the DON of the above concerns with BS, orders not being followed, PN, no documented evidence the physician was notified of changes to the resident, no further monitoring of BS in the eMAR, nurse did not sign and did not document that the PRN orders for hypoglycemic were administered. The DON stated that the physician should have been notified, documented the BS in the eMAR, signed the PRN orders for hypoglycemic, and the nurse should have done eInteract, and followed up the BS. S #2 asked for copy of policies with regard to notification of changes and following PO. On [DATE] at 9:22 AM, S #2 interviewed LPN #2, who informed S #2 that as per facility's process or standard of practice, when a resident had change in condition, example was hypoglycemia, we give orange juice and milk according to the PO. LPN #2 stated that if it was very low like 40 or below we give glucagon IM (intramuscularly), sign the eMAR, monitor, call the doctor, and obtain further orders. She further stated that afterward we document in the electronic medical record, PN, we also do SBAR. At that time, S #2 notified LPN #2 of the above findings and concerns. LPN #2 informed S #2 that she remembered that day, the resident was alert and oriented, non-compliant with fluid restrictions on dialysis, and it was the first time that the resident the hypoglycemia. She added that it was morning when I came in and I was doing rounds when the Certified Nursing Aide (CNA) notified her about the resident would not want to eat and looked like lethargic but awake. LPN #2 stated that she could not remember the CNA at that time. LPN #2 further stated that she gave glucose syrup notified the Nursing Supervisor, I rechecked 5-10 minutes it was still low the BS then the DON came, the BS then was 36, and I administered the glucagon IM, I called the doctor, and I remembered the doctor screamed on me because he was rounding in the hospital when I called and ordered to give another dose of glucagon IM. Afterward, LPN #2 stated that she was unsure if she documented that she called the doctor at that time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 1:47 PM, the survey team met with the LNHA and DON, and S #2 notified them of the above findings and concerns with Resident #120. On [DATE] at 11:43 AM, the survey team met with the LNHA and DON. The DON stated there was no policy with regard to SBAR and eInteract, it was just a tool that we follow and do. The LNHA stated that there was no additional information to provide. A review of the facility's Notification of Changes Policy that was provided by the DON, with a reviewed/revised date of [DATE], revealed under policy: the purpose is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification.Compliance Guidelines: the facility must inform the resident, consult with the resident's physician when there is a change requiring such notification. Further review of the above Notification of Changes Policy did not include information documentation of notification. On [DATE] at 1:50 PM, the survey team met with the LNHA, DON and [NAME] President of Clinical Services for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-3.2(a,b); 11.2(b); 27.1(a)

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	315460	A. Building B. Wing	01/29/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, review of the medical record, and review of other facility documentation, the facility failed to maintain infection control practices to reduce the risk of infection during 1 of 1 wound treatment observed (Resident's #7). This deficient practice was evidenced by the following:On 1/21/26 at 11:12 AM, the surveyor observed Resident #7 sleeping in bed. A review of Resident #7's admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; fracture of left femur, dementia and hypertension. A review of Resident #7's most recent Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the resident's cognitive skills for daily decision making were severely impaired. On 1/28/26 at 10:18 AM, the Licensed Practical Nurse (LPN) started Resident #7's wound treatment for both heels and right ankle. The LPN while placing some of the supplies on the table doffed (take off) her gloves and performed hand hygiene (hh) and donned (put on) a new pair of gloves. The LPN opened the border gauze dressing, put her hand in her pants pocket and removed a marker from her pocket. The LPN did not disinfect the marker. The LPN then dated the dressing and placed the marker back in her pocket. The LPN then doffed her gloves and donned a new pair of gloves. The LPN did not perform hh after doffing her gloves and before donning the new pair. The LPN then started the treatment for the right heel. After the LPN wiped dry the right heel the LPN performed handwashing (hw) for 9 seconds outside the flow of water. The LPN donned a pair of new gloves, wiped the resident's right ankle with a saline soaked 4 x 4 dressing. The LPN doffed her gloves then donned a new pair of gloves. The LPN did not perform hh. Later in the treatment for the left heel, the LPN performed hw for 20 seconds outside the flow water, rinsed her hands and then turned off the faucet with her wet hand before taking a paper towel to dry her hands. The LPN did not use a new dry paper towel to turn off the faucet. At the end of the treatment, after performing appropriate hw and donning gloves, the LPN removed all the supplies from the table and threw them in a plastic bag. The LPN then removed her gown and gloves and left the room. The LPN did not perform hh and then proceeded to touch the handle of the treatment cart. The LPN then put her hand in her pocket to remove the keys to the treatment cart and opened the cart. The LPN then donned a new pair of gloves and took out disinfectant wipes from the treatment cart. In addition, during the wound treatments of both heels, the Assistant Director of Nursing (ADON) was holding the resident's legs. The LPN did not put down a clean surface under the resident's heels during the treatments. The surveyor observed that the resident's heels were close to touching the bed sheet and the blanket on more than one occasion. The surveyor then interviewed the LPN regarding the wound treatment observation. The LPN stated that she took the marker out her pocket and that she made a mistake and should have performed hh after removing gown and gloves. On 1/28/26 at 11:57 AM, the surveyor interviewed the Infection Preventionist Nurse (IPN) regarding wound treatment. The IPN stated that she had to get back to the surveyor regarding the marker. The IPN stated that it was good practice to place something under the area but that it was not mandatory. The IPN stated that hh should be performed before putting on gloves and after removing gloves. The IPN further stated that the faucet should be running while drying hands and that the faucet would be shut after hands were dried and with a new paper towel. The IPN also stated that the LPN was good and that she just got nervous. The IPN stated that the nurses were constantly in-serviced. On 1/28/26 at 12:46 PM, the IPN stated that if the nurse pulled the marker from her pocket, wrote on the dressing, put it back in her pocket and then changed gloves, that it was okay. On 1/28/26 at 2:22 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concerns regarding Resident #7's wound treatment observation which included not disinfecting the marker, hw for 9 seconds, not performing hh several times after removing gloves, turning off the faucet with wet hand, and not placing a clean surface under the resident's feet. On 1/29/26 at 11:43 AM, in the presence of the LNHA, the DON stated that in regards to the hand hygiene during treatment (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation the nurse was brand new and that she was not going to dispute the handwashing. The LNHA did not provide any additional information. A review of the facility's Wound Treatment Management Policy with a reviewed/revised date of 9/1/25, included the following: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician order.The policy did not contain any information regarding process for the wound treatment. A review of the facility's Hand Hygiene Policy with a reviewed/revised date of 9/1/25, included the following: All staff will perform proper hand hygiene to prevent the spread of infection to other personnel, residents, and visitors.1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.5. Hand hygiene technique when using soap and water: c. Rub hands together vigorously for at least 20 seconds.e .Dry thoroughly with a single-use towel.f. Use clean towel to turn off the faucet.6. Additional considerations:a. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. N.J.A.C. 8:39-19.4(a)k

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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. Based on observation, interview, and record review, it was determined that the facility failed to: a.) clarify physician's orders (PO) to ensure appropriate care and services for a resident receiving enteral feedings, and b.) to notify the physician of a weight gain of 2-5 pounds (lbs.) as per physician order. This deficient practice was identified for 1 of 2 residents (Resident #51), reviewed for enteral tube feeding.This deficient practice was evidenced by the following: On 1/21/26 at 11:17 AM, the surveyor observed the resident sitting in a wheelchair, not able to answer questions. The surveyor interviewed the 5th floor Registered Nurse/Unit Manager (RN/UM), who stated Resident #51 was on a bolus TF (TF-liquid formula directly to the stomach or small intestine via a tube for those who are unable to take nutrition by mouth). A review of the admission Record (an admission summary) which revealed diagnoses that included but not limited to; pneumonia, acute respiratory failure with hypoxia, dysphagia (difficulty swallowing), and chronic diastolic congestive heart failure. A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 1/13/26, revealed a Brief Interview of Mental Status (BIMS) score of 3 out of 15 indicating severe cognitive impairment, and that the resident was on a TF. A review of the resident's Care Plan (CP) included that Resident #51 was at nutritional/hydration risk due to: NPO (nothing by mouth), date initiated on 1/7/26. The resident required TF related to (r/t) dysphagia, date initiated on 1/6/2026. A review of the Order Summary revealed the following PO:-Ordered on 1/6/25, NPO diet NPO texture, NPO consistency.-Ordered on 1/15/26, Enteral Feed order five times a day Jevity 1.5, 237 ml (milliliters) bolus via PEG (stands for Percutaneous Endoscopic Gastrostomy, a minimally invasive procedure used to insert a feeding tube directly into the stomach through the abdominal wall. This tube, often called a TF, provides nutrition, fluids, and medication to patients who cannot swallow or consume food orally due to stroke, cancer, or neurological conditions), Total provides 1775 kcal/day (kilo calorie/day).-Ordered on 1/6/26, Milk of Magnesia (MOM) Suspension 1200 mg/15 ml (milligrams/milliliters) Give 30 ml by mouth as needed (PRN) for constipation give at bedtime (HS) on the 3rd day of no bowel movement.-Ordered on 1/6/26, Acetaminophen (Tylenol) Tablet (tab) 325 MG Give 2 tablets (tabs) by mouth every 4 hours PRN for pain rate 1-3 total does not to exceed 650 mg not to exceed 3 grams/24 Hour.-Ordered on 1/6/26, Daily Weight- Notify the physician for a weight gain of 2 lbs or more within 24 hours and/or 5 lbs or more within one week, everyday shift. A review of the resident's weight revealed on 1/21/26 a weight of 102.8 lbs. and on 1/22/26 a weight of 105.6 lbs. (2.8 lbs. weight gain). On 1/23/26 at 10:50 AM, the surveyor reviewed with the 5th floor RN/UM regarding the concerns on the electronic Medication Administration Record (eMAR), the orders for Tylenol, MOM by mouth, and the order to notify physician for weight gain (2-5lbs.). The RN/UM confirmed the order for Tylenol and MOM were entered incorrectly. The RN/UM further stated that they (nurse) should have called the doctor for the 2-5 lbs. weight gain on 1/22/26 as ordered. On 1/23/26 at 11:16 AM, the surveyor and the RN/UM reviewed all the nursing progress notes (PN) and the RN/UM confirmed that for 1/22/26 2.8 lbs. weight gain, the doctor was not notified of the weight gain, and PO was not followed. She further stated that it was the responsibility of the nurses to notify the doctor and follow the PO. On 1/28/26 at 2:36 PM, the survey team met with the License Nursing Home Administrator (LNHA), and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. The DON stated that medications were corrected after surveyor's inquiry. On 1/29/26 at 9:15 AM, the surveyor notified the DON regarding the concern with the physician order not being followed for notifying physician for weight gain. On 1/29/26 at 11:45 AM, the survey team met with the LNHA and the DON, and there was no further information provided by the LNHA. A review of the facility's Provision of Physician Ordered Services Policy dated 9/1/25, revealed under Definition, Professional Standards of Quality means that care and all services are provided according to accepted standards (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of clinical practice . A review of the facility's Medication Administration Policy dated 9/1/25, revealed under Policy Explanation and Compliance Guidelines #12c . administer in accordance with facility policy for the relevant route of administration . NJAC 8:39-27.1(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, it was determined that the facility failed to provide care and services in accordance with professional standards with regard to a.) medication administration to accommodate dialysis schedule times and b.) following the physician's order for fluid restriction for 1 of 2 residents, (Resident #94), reviewed for dialysis services, 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. On 1/21/26 at10:59 AM, the surveyor observed Resident #94 was not in their room. The 5th floor Registered Nurse/Unit Manager (RN/UM) stated the resident was in the rehabilitation gym. The RN/UM also stated the resident's dialysis days were on Tuesdays (Tue), Thursdays (Thu), and Saturdays (Sat). On 1/22/26 at 11:28 AM, the resident was out for dialysis and the RN/UM stated that the resident left at 9:00 AM and would come back to the facility at around 2:30 PM-3:00 PM. A review of the admission Record (an admission summary) revealed diagnoses which included but not limited to type 2 diabetes mellitus with diabetic chronic kidney disease and end stage renal disease (ESRD). A review of the comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/19/25, revealed a Brief Interview of Mental Status (BIMS) score of 11 out of 15 indicating moderate cognitive impairment, and that resident was on dialysis. A review of the resident's Care Plan (CP) indicated the resident with renal insufficiency related to ESRD. A review of the Order Summary Report revealed the following Physician Order (PO):-Ordered on 12/15/25, for Dialysis on Tue, Thu, and Sat; pick up time at 10:00 AM and chair time at 10:30 AM.-Ordered on12/12/25, for Furosemide (diuretic) Oral Tablet (tab) 40 mg (milligram) Give 1 tab by mouth in the morning for edema hold for SBP (systolic blood pressure) less than 100.-Ordered on 1/12/26, for Fluid restriction as ordered: 1000 ml (milliliters). Noted fluids from ONS (supplement) was not included.7 AM - 3 PM shift: 590 ml (nursing: 110 ml; dietary: 480 ml)3 PM - 11 PM shift: 350 ml (nursing: 110 ml; dietary: 240 ml)11 PM - 7 AM shift: 60 ml (nursing: 60 ml; dietary: 0 ml)Total 1000 ml every shift. Further review of the electronic Medication Administration Record (eMAR) revealed the PO for fluid restriction was not followed on the following dates:On 1/13/26, a total volume (TV) of 1050 ml was administered.On 1/14/26, a TV of 1050 ml was administered.On 1/15/26, a TV of 1770 ml was administered.On 1/16/26, a TV of 2180 ml was administered.On 1/17/26, a TV of 1290 ml was administered.On 1/18/26, a TV of 1770 ml was administered. -Ordered on 12/22/25, for Brimonidine Tartrate Ophthalmic Solution 0.2 %. Instill 1 drop in both eyes three times a day for glaucoma was timed for 9:00 AM, 1:00 PM, and 5:00 PM.Further review of the eMAR revealed on 1/3/26, 1/6/26, 1/8/26, 1/10/26, 1/15/26, and 1/17/26, revealed a legend #7 (out to dialysis) was documented and medication (med) was not administered. -Ordered on 12/12/25, for Gabapentin Capsule (cap) 100 mg. Give 1 cap by mouth three times a day every Tue, Thu, Sat for Neuropathy was timed for 9:00 AM 2:00 PM, and 5:00 PM. Further review of the eMAR revealed on 1/3/26, 1/6/26, 1/8/26, 1/10/26, 1/15/26, and 1/17/26, revealed a legend #7 (out to dialysis) was documented and med was not administered. On 1/23/26 at 9:57 AM, the surveyor observed Resident #94 lying in bed, with no fluids on the bedside (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	table, and stated they felt good. On 1/23/26 at 10:12 AM, the surveyor reviewed with the RN/UM, in the presence of the primary License Practical Nurse (LPN), regarding the Brimonidine ophthalmic solution and Gabapentin medications (meds) were not administered due to resident out on dialysis and the fluid restriction not followed. The LPN stated that the resident came back yesterday at 2:45 PM from dialysis. The RN/UM and the LPN also reviewed all the nursing progress notes (PN) and confirmed the meds should have been adjusted according to dialysis time. Both also acknowledged the order for fluid restriction was not followed. The RN/UM stated, We have to correct that one now. On 1/28/26 at 2:32 PM, the survey team met with the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and the surveyor notified of the above findings and concerns concerning the meds and fluid restriction orders. The DON stated that regarding the fluid restriction, the resident was noncompliant. The surveyor asked what was the expectation from nurses when a resident was noncompliant with fluid restrictions, and the DON replied, I expect them to call the doctor and clarify and document. The surveyor asked the DON if the nurses documented each time, and there was no response from the DON. Later, the DON stated that noncompliance of the resident was included in the CP after surveyor's inquiry. On 1/29/26 at 11:45 AM, the survey team met with the LNHA and the DON, and there was no further information provided by the LNHA. A review of the facility's Hemodialysis Policy dated 9/1/25, revealed under Compliance Guidelines #9, The facility will communicate with the attending physician any .med withholding of certain meds #13g, The facility will ensure that the PO for dialysis include: Any fluid restriction if ordered by the physician . A review of the facility's Fluid Restriction Policy dated 9/1/25, revealed under Policy, It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to PO . NJAC 8:39-11.2(b),27.1(a),29.2(d)

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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. Complaint NJ#s: 384182, 384183, 384186, 384188, 2573473, and 2615149Based 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 residents received timely and appropriate incontinent care to achieve their highest practical wellbeing. This deficient practice was identified for 1 of 4 residents (Resident#13) observed during incontinence round, and was evidenced by the following:On 1/21/26 at 9:07 AM, the survey team entered the facility and observed the Nursing Home Resident Care Staffing Report (NHRCSR) for 1/21/26, 7 AM-3 PM shift with a census of 118 and the ratio of the Certified Nursing Aide (CNA) to Resident was 1:14.8. A review of the provided nursing staffing schedule for 1/21/26, revealed that there were total of 28 residents in the 5th floor nursing unit and two CNAs. On 1/21/26 at 11:40 AM, the surveyor went to 5th floor and interviewed the CNA, and the surveyor asked the CNA how many residents she had in her assignment. The CNA responded, a lot, I cannot even tell you how many. She stated about 14 residents, and she stated it was hard, but she was doing everything to finish. She further stated right now she was not done with am (morning) care. She confirmed that there were only two CNAs in the 5th floor unit. The CNA informed the surveyor that they (CNA) utilized the electronic medical records for signing off care provided to the resident that included incontinent care. On 1/22/26 at 8:52 AM, the surveyor went to 3rd floor nursing unit and observed an NHRCSR posted dated 1/22/26, 7 AM-3 PM shift, current census was 117, there were total of 10 CNAs, and the ratio 1 CNA:11.7 Residents. On 1/23/26 at 8:50 AM, the surveyor asked the 5th floor Registered Nurse/Unit Manager (RN/UM) to accompany the surveyor for incontinence round. The RN/UM confirmed that Resident #13 was incontinent with both bladder and bowel elimination. Both the surveyor and the RN/UM went inside the resident's room, and the resident allowed the RN/UM to check their incontinence brief. The surveyor observed the RN/UM performed hand hygiene, donned (put on) gloves, and checked the resident's incontinence brief. Both the surveyor and the RN/UM observed Resident #13 with double incontinence briefs and wet with urine. The surveyor did not observe skin impairment in the sacrum. On that same date and time, the surveyor observed the RN/UM checked Resident #13's pads and the RN/UM confirmed it was wet beyond the pads that included folded linen and cloth type chuck and there was a smell of urine. The RN/UM informed the resident that she would clean the resident herself. At that same time, the surveyor observed the RN/UM went to the resident's toilet room and performed handwashing. The RN/UM stated that she was unaware that the resident requested double incontinence briefs, and if the resident did ask, that should have been in the resident's care plan (CP). The RN/UM further stated that she was unsure if it was in the CP. She also added that the facility did not allow double incontinence brief unless it was asked by the resident due to risk of skin impairment, and that the nurse should be aware to be added in the CP. The surveyor was unable to interview the CNA assigned to the resident at that time. On 1/23/26 at 10:29 AM, the surveyor reviewed the medical records of Resident #13, and revealed: A review of the admission Record or face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but were not limited to; type 2 diabetes mellitus without complications, chronic obstructive pulmonary disease unspecified, need for assistance with personal care, and difficulty in walking not elsewhere classified. A review of the personalized CP reflected a focus that the resident had potential impairment to skin integrity that was revised on 9/15/25, with an interventions that included but was not limited to assist with toileting needs. Further review of the CP for Resident #13 revealed there was no CP that the resident preferred to have double incontinence brief. There was no documented evidence that the resident had requested for double incontinence briefs. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/9/25, the brief interview for mental status (BIMS) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	score was 15 out of 15, which reflected that the resident was cognitively intact. Section GG Functional Abilities: under toileting hygiene was coded 1 (dependent) and toilet transfer was coded 1. Section H Bladder and Bowel was coded 3 (always incontinent) for both bladder and bowel. Section M Skin Conditions=no skin impairment. On 1/23/26 at 12:16 PM, the surveyor reviewed the toileting hygiene task of the CNA in the electronic medical records and revealed, from 1/10/26 to 1/22/26, the question, the ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. were checked off every shift. In addition, the toileting hygiene task revealed on 1/23/26, there was only one shift that signed off the task at 00:17 (12:17 AM),reflected that the resident was dependent, and required the assistance of two or more helpers for the resident to complete the activity. Further review of the toileting hygiene task revealed on 1/23/26, there was no documented evidence that the 7 AM-3 PM shift had signed off the task to reflect that care was provided, and no documented evidence that after 12:17 AM of 1/23/26, that incontinence care was provided. On 1/23/2026 12:20 PM A review of the provided List of Incontinent Residents by the Licensed Nursing Home Administrator (LNHA) revealed that Resident #13 was included. A review of the provided nursing staffing schedule for 1/23/26, revealed a census of 112 and there were two CNAs on the 5th floor in 7 AM - 3 PM shift. On 1/28/26 at 1:47 PM, the survey team met with the LNHA and Director of Nursing (DON), and the surveyor notified them of the above findings and concerns with Resident #13. On 1/29/26 at 10:29 AM, the surveyor met with the LNHA and DON for QAPI (Quality Assurance Performance Improvement) meeting and discussed the Facility Assessment that was provided to the surveyor with regard to staffing requirements. The LNHA confirmed that staffing concern had been part of facility's QAPI, and he was aware that the facility at times were unable to meet the New Jersey (NJ) required minimum staffing requirements or ratio for 1 CNA:8 Residents for 7 AM-3 PM, 1 CNA:10 Resident for 3 PM-11 PM, and 1 CNA:14 Residents for 11 PM-7 AM. On 1/29/26 at 11:43 AM, the survey team met with the LNHA and the DON for responses. The DON informed the surveyors that after inquiry with the staff, it was found out that it was the first time the resident had asked for double incontinence briefs, and CP was updated to include the resident's request after surveyor's inquiry and observation. The DON further stated that aid was provided a one on one in service. A review of the facility's Activities of Daily Living Policy that was provided by the DON, with a reviewed/revised date of 10/1/25, reflected under policy statement, residents will provide with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out ADLs independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Policy Interpretation and Implementation.2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care, including appropriate support and assistance with: a. Hygiene.c. Elimination (toileting).A review of the facility's Incontinence Policy that was provided by the LNHA, with a reviewed/revised date of 9/1/25, reflected, based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. Policy Explanation and Compliance Guidelines: .4. Residents that are incontinent with bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. On 1/29/26 at 1:50 PM, the survey team met with the LNHA, DON and [NAME] President of Clinical Services for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-25.2(b); 27.2(h)

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to ensure the accurate daily report of licensed nurses, certified nursing assistant staffing, and the resident census was posted at the beginning of the current shift for 3 of 6 days during the annual re-certification survey.This deficient practice was evidenced by the following: On 1/21/26 at 9:07 AM, the survey team entered the facility. The surveyor observed the Nursing Home Resident Care Staffing Report (NHRCSR) posted at the front desk by the receptionist. The NHRCSR posted was dated 1/21/26, for the 7 AM-3 PM day shift with a current resident census of 118. The Licensed Nursing Home Administrator (LNHA) informed the survey team on entrance that the resident census was 117 with no bed hold. There was a discrepancy on the provided census on admission and what was posted in the NHRCSR on 1/21/26. On 1/22/26 at 9:00 AM, the surveyor observed the NHRCSR posted by the front desk for 1/22/26, 7 AM-3 PM shift with a resident census of 117. The LNHA provided the staffing sheet at 11:18 AM, which reflected a census for 118. The posted NHRCSR census of 117 did not match the provided staffing sheet census of 118 on 1/22/26. On 1/23/26 at 8:37 AM, the surveyor interviewed the Receptionist by the front desk, who stated, The Staffing Coordinator (SC) is responsible for posting this (NHRCSR), posted around 8 AM. On 1/23/26 at 9:28 AM, the surveyor interviewed the SC who stated that on a daily basis I run the schedule, do the count, come early in the morning, input in the state report, then print it out and post it in the lobby around 7-7:30 AM. The SC further stated that sometimes she would call the Supervisor to post it if I am out or running late. The SC also stated that she was responsible for posting and that I am aware of the regulation that the numbers should be accurate, staff versus residents. On 1/27/26 at 10: 50 AM, the surveyor observed the NHRCSR posted with a resident census of 116. The LNHA provided the staffing sheet with census of 118. On 1/28/26 at 2:40 PM, the survey team met with the LNHA and the Director of Nursing (DON), and the surveyor notified them of the above findings and concerns with the NHRCSR and staffing sheet discrepancies. On 1/29/26 at 11:14 AM, the surveyor notified the SC regarding the three days posted NHRCSR did not match the census in the staffing sheets. The SC stated, I do send out the staffing with the census of that date, the night before. I do change it the morning that I come in. The posting for those days should have been accurate. On 1/29/26 at 11:45 AM, the survey team met with the LNHA and the DON. The LNHA stated that the staffing reporting was done the night before and that there were two discharges that did not come in after midnight. The LNHA stated that he was aware of the regulation that the posted staffing should be accurate and posted the beginning of each shift. He further stated that the posted NHRCSR was not changed before 7AM. The LNHA stated that they had the whole day to update or revised the NHRCSR the following day. A review of the facility's Staffing Policy dated 9/1/25, revealed under Policy Statement, Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans .The facility policy did not include information about the regulations for posting and the management staff stated there were no other policies for staffing. NJAC 8:39-41.2(a,b,c,d)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on observation, interview, review of the medical record, and review of other facility documentation, it was determined that the facility failed to a.) ensure that a resident received a monthly medication review from a pharmacy consultant for 1 of 5 residents reviewed for unnecessary medication (Resident #12) and b.) act on the Consultant Pharmacist (CP) Medication Regimen Review (MRR) in a timely manner for 1 of 5 residents, (Resident #48), observed on the medication pass observation (med pass).This deficient practice was evidenced by the following: 1.On 1/21/26 at 10:44 AM, Surveyor #1 (S #1) observed Resident #12 lying asleep in bed. A review of Resident #12's admission Record (AR; admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; dementia, hemiplegia and hemiparesis, and hypertension. A review of Resident #12's most recent comprehensive Minimum Data Set (MDS) reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 10 out of 15, which indicated the resident's cognition was moderately impaired. A review of Resident #12's Progress Notes (PN) indicated that the last pharmacy consultant visit was on 11/30/25. A review of Resident #12's electronic medical record (EMR) did not reflect any CP document that was uploaded. On 1/27/26 at 1:12 PM, S #1 interviewed the 6th floor Registered Nurse/Unit Manager (RN/UM) who stated that the CP visited one time a month and that the report went to the Director of Nursing (DON). On 1/27/26 at 1:15 PM, S #1 interviewed the DON who stated that the CP visited monthly. S #1 asked if the expectation was for the CP to review all the residents. The DON stated that the CP was expected to review everyone and that they had access to the EMR. The DON added that the CP reviewed residents when they returned from a hospital stay. On 1/27/26 at 1:55 PM, S #1 notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that Resident #12's last MMR done by the CP documented in the resident's medical record was on 11/30/25. On 1/28/26 at 2:03 PM, in the presence of the LNHA, the DON provided S #1 with a document that was dated 1/6/26 from the CP which had listed no recommendations and included the following: Permanent Record-Do Not Remove-Do Not Thin. S #1 asked the DON if the document should have been part of the resident's medical record. The DON stated that the CP was at the facility on 12/30/25 and 12/31/25, and that the resident was in the hospital then. The DON stated that the resident returned to the facility on 1/6/26. S #1 notified the DON that the document was not uploaded into the EMR. The DON stated that the document was not uploaded since the CP would document a note in the PN. S #1 notified the DON that there was not a PN in the resident's medical record for the 1/6/26 visit. The LNHA did not provide any additional information. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Medication Monitoring/Side Effects Policy with a reviewed/revised date of 9/1/25, included the following: 6. Each resident's medication regimen is reviewed by a licensed pharmacist at designated intervals and whenever changes in condition that could be related to medications are noted. 2. On 1/23/26 at 8:44 AM, Surveyor #2 (S #2) observed Licensed Practical Nurse #1 (LPN #1) assigned to Resident #48 prepare and administer due medications (meds) for the resident. S #2 observed the LPN #1 prepare one docusate sodium (stool softener) 100 mg (milligram) capsule (cap) and 10 ml (milliliters) of docusate sodium 50 mg/5ml liquid. S #2 observed these orders on the resident's electronic medication administration record (eMAR) displayed on LPN #1's computer screen. S #2 asked LPN #1 why they were giving the same medication (med) in cap and liquid form to the resident. LPN #1 stated that the resident was very constipated and they needed it. LPN #1 documented the administration of meds and S #2 concluded the observation. S #2 reviewed the EM for Resident #48. A review of the AR reflected that the resident was admitted to the facility with diagnoses of, but not limited to malignant neoplasm of prostate (prostate cancer) and obstructive and reflux uropathy (blockage and back flow of urine in the urinary tract). A review of the quarterly MDS, with an ARD of 12/15/25, under Section C revealed a BIMS score of 6 out of 15, indicating that the resident had severe cognitive impairment. Section H, Bladder and Bowel, revealed that the resident was frequently incontinent of bowel. A review of Order Summary Report reflected the following orders: Colace Oral cap 100 mg Give 1 cap by mouth two times a day for constipation, with an order date of 3/19/24. Docusate Sodium Oral Liquid 50 mg/5 ml Give 10 ml by mouth two times a day for Constipation, with an order date of 10/28/25. A review of the resident's eMAR revealed the same orders scheduled at 9:00 AM and 5:00 PM and documented as being given at those times. The eMAR also reflected that the Docusate Liquid order was discontinued and not given as of 1/29/26, after surveyor's inquiry. S #2 reviewed the CP reports for Resident #48. The reports revealed on 10/22/25, the CP made a recommendation to the facility for Resident #48 to change the Docusate cap order to liquid form as resident needs meds crushed, as the capsules (caps) cannot be crushed. The report also reflected that the facility response was -med changed to liquid form. Further review of the CP reports revealed a CP recommendation dated 12/30/25, that reflected, Colace appeared twice on the eMAR- liquid & caps @ 9 AM and 5 PM. Please confirm both orders and discontinue one order if needed. There was no response documented on the report. On 1/28/26 at 1:47 PM, the survey team met with the LNHA and DON, and S #2 notified them of the above findings and concerns of duplicate meds ordered and the CP's recommendations were not followed. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/26 at 11:44 AM, the survey team met with the LNHA and DON, and there was no additional information provided by the LNHA. A review of the facility's Pharmacy Services Policy, dated revised 9/1/25, the policy did not reflect any mention of the facility responding to or acting on CP recommendations or any time frame to do so. NJAC 8:39-29.3(a)(1)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview, record review, and review of pertinent documentation, it was determined that the facility failed to ensure that the resident (Resident #15) did not receive an unnecessary medication by inaccurate or unknown dose for 1 of 5 residents, (Resident #15), reviewed for unnecessary medications.The deficient practice was evidenced by the following: The surveyor reviewed Resident #15's electronic medical record (EMR) which revealed the following: A review of the admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but not limited to; atrial fibrillation (rapid uncontrolled heartbeat), essential hypertension (high blood pressure), and muscle weakness. A review of Resident #15's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an assessment reference date (ARD) of 12/10/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident has no cognitive impairment. A review of the resident's Comprehensive Care Plan (CCP), dated 12/3/25, which reflected that the resident had left foot pain. A review of the Order Summary Report (OSR), reflected the following active physician orders (PO) as of 1/22/26, which reflected the following medication (med) orders:Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to Left hip topically two times a day for pain.Diclofenac Sodium External Gel 1 % (Diclofenac Sodium (Topical)) Apply to left knee topically two times a day for pain. A review of the resident's electronic medication administration (eMAR) revealed the following orders that matched the OSR.Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical)) Apply to Left hip topically two times a day for pain -Order Date-1/21/26Diclofenac Sodium External Gel 1% (Diclofenac Sodium (Topical)) Apply to left knee topically two times a day for pain -Order Date-1/21/26 On 1/22/26 at 9:54 AM, the surveyor interviewed the resident and the surveyor asked the resident how they get the Diclofenac Gel from the staff. The resident stated that the nurse comes in with it in a small cup. On 1/22/26 at 10:06 AM, the surveyor interviewed the Registered Nurse (RN) who was assigned to care for Resident #15 that day. The surveyor asked the RN how they administered the Diclofenac Gel and how they know how much was used. The RN stated it depends on the area. Some residents get a little for a small area and some need more if there was a bigger area. The RN further stated, Maybe the size of a fingertip or more. The RN did not state any amount or a dose. On 1/28/26 at 1:47 PM the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON), and the surveyor notified them of the above findings and concerns. On 1/28/26 at 3:00 PM, the surveyor contacted the facility consultant pharmacist (CP) by phone and the surveyor asked the CP how Diclofenac Gel was given and if there was a dose that was used. The CP stated that the dose was either 2 grams or 4 grams measured on a dose card that comes with the product, depending on where it was going to be applied. The surveyor reviewed the manufacturer package insert (PI) Voltaren Gel, otherwise known as Diclofenac Gel. The PI reflected under Dosage and Administration: Voltaren Gel should be measured onto the enclosed dosing card to the appropriate 2-gram or 4-gram designation. Lower extremities: apply 4 grams. Upper extremities apply 2 grams. On 1/29/26 at 11:44 AM, the survey team met with the LNHA and DON, and there were no further information provided by the LNHA and DON. A review of the facility's Medication Administration Policy, Reviewed/Revised date of 9/1/2025, the policy reflected, under 10. c. Right Dosage, 12. Compare med.to verify.dose. a. Refer to drug reference material if unfamiliar with the med. NJAC 8:39-27.1(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store and/or label medication per manufacturer specifications and standards of practice. This deficient practice was identified in 1 of 2 medication carts (med cart) observed during the medication pass (med pass) observation and 1 of 5 med carts observed during the med storage 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 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 1/23/26 at 9:05 AM, the surveyor observed Licensed Practical Nurse #1 (LPN #1) assigned to the 4th floor east prepare and administer medications (meds) to Resident #114. The surveyor observed LPN #1 entered the resident's room to administer due meds and leave a bottle of Aspirin 81 mg (milligram) chewable tablets (tabs) unattended on top of the med cart. On the same day at 9:47 AM, the surveyor observed LPN #1 prepare and administer meds to Resident #131. The surveyor observed LPN #1 entered the resident's room to administer due meds and leave a package containing methylprednisolone (Medrol, a steroid med used for swelling) tablets (tabs), unattended on top of the med cart covered by a sheet of paper. The surveyor concluded the observation. On 1/28/26 at 11:19 AM, the surveyor observed the med cart located on the east 4th floor, in the bottom drawer, a plastic bag containing a Trelegy inhaler (inhaled med used to treat asthma or COPD (chronic obstructive pulmonary disease). The surveyor observed that the inhaler had a resident's name and a date written on it in black marker ink. The surveyor also observed that the inhaler did not have any labeling affixed by the facility provider pharmacy or other pharmacy. The surveyor asked Licensed Practical Nurse #2 (LPN #2) assigned to the med cart whose inhaler it was and why it was in the med cart without a label. LPN #2 stated that it belonged to Resident #41, and was probably brought from the hospital or from home. The surveyor asked LPN #2 what the date written on the inhaler meant. LPN #2 stated that the resident told us when it was opened. The surveyor also observed another Trelegy inhaler in the med cart in a manufacturer box with a pharmacy label and a pharmacy label on the inhaler itself. The labels reflected that the inhaler was for Resident #41. The surveyor asked LPN #2 which inhaler was being used and how would staff know which one to use. LPN #2 stated that the inhaler from the provider pharmacy was used and the other (unlabeled) inhaler was just kept there but can be disposed of if needed. The surveyor concluded the observation. On 1/28/26 at 1:47 PM the survey team met with the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) to inform of concerns. The surveyor notified the LNHA and DON of the concerns with storage of medications (meds), meds being left unattended and unlabeled inhaler. The DON responded that the inhaler was resident property and that the facility wanted to keep it secure. The surveyor stated that the med cart contained active in-use meds and asked if there would be any other place to store it. The DON stated that the med cart was always locked and the best place. On 1/28/26 at 3:00 PM, the surveyor contacted the facility consultant pharmacist (CP) by phone. The surveyor asked the CP if meds should be left on top of the med cart and if meds should have proper labels from the pharmacy. The CP stated that meds should not be left on top of the med cart and meds should have proper labels or removed from the active meds and stored elsewhere such as the med room. On 1/29/26 at 11:44 AM, the survey team met with the LNHA and DON for responses to concerns. The LNHA and DON had nothing further regarding the med storage concerns. A review of the facility's Medication Storage Policy, dated reviewed/revised 9/1/25, the policy reflected under General Guidelines: All drugs and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	biologicals will be stored in locked compartments. The policy did not reflect anything relating to labeling of meds. NJAC 8:39-29.4(d)(g)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and policy review, it was determined that the facility failed to maintain essential kitchen equipment in safe operating condition for 2 of 2 days of observation. This deficient practice was evidenced by the following: On 1/21/26 at 9:45 AM, in the presence of the Food Services Director (FSD), the surveyor observed a leaking sink located in the middle of the food preparation area. The FSD was unable to turn off the sink with the faucet handles. The FSD stated she did not know about the leaking sink and stated, I will have them come check. On 1/22/26 during a follow-up kitchen tour, the surveyor observed that the sink in the meal prep area continued to have a steady leak ongoing. A review of the facility's Kitchen cleaning policy dated 9/1/25, revealed, the policy indicated that the staff shall maintain the sanitation of the kitchen. During an interview on 1/22/26 at 2:00 PM, the surveyor brought the above concerns to the attention of the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON). On 1/29/26 at 1:50 PM, the survey team met with the LNHA, DON and [NAME] President of Clinical Services for exit conference, and there was no additional information provided by the LNHA. NJAC 8:39-31.2(e)