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 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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315460	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2026
NAME OF PROVIDER OR SUPPLIER: Complete Care at Prospect Heights LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 336 Prospect Ave, Hackensack, NJ 07601	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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) 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)