STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315377	A. BUILDING _____ B. WING _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTORS FUND HOME, THE	**175 WEST HUDSON AVE ENGLEWOOD, NJ 07631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 02/05/2024 Census: 93 Sample: 19 + 3 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		2/8/24

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

Electronically Signed | 02/07/2024

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

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F 623	Continued From page 1 before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with	F 623		

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, interviews and review of pertinent facility documents it was determined that the facility failed to notify a representative from the Office of the State of Long-Term Care Ombudsman about a resident's emergency transfer to the hospital. This deficient practice was identified for 1 of 1 resident, (Resident #74) reviewed for hospitalization as was evidenced by	F 623	F 623 NOTICE REQUIREMENTS FOR TRANSFER / DISCHARGE 1. Facility failed to notify the Ombudsman's Office about discharges within 30 days of a resident being discharged from the facility. Resident #74 was NJ Exec Order 28.4b1 from the facility on	

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F 623	Continued From page 3 the following: Review of Resident #74s Face sheet (an admission summary), indicated that the resident was NJ Exec Order 26.4b1 on NJ Exec Order 26.4 with a return NJ Exec [redacted]. Review of the progress note dated NJ Exec Order 26.4 at 6:21 PM, reflected that Resident #74 was sent to the emergency room for evaluation. Review of a progress note dated NJ Exec Order 26.4b1 [redacted] reflected that Resident #74 was admitted to the hospital. Review of the facility's Notice of Emergency Transfer dated NJ Exec Order 26.4, reflected that the resident was sent out to the emergency room on NJ Exec Order 26. for evaluation and treatment. Review of an email to the Office of the New Jersey Long-Term Care Ombudsman dated NJ Exec Order 26.4b reflected that the facility notified the office of resident's emergency transfers for the time period of NJ Exec Order 26.4b1 [redacted] On 2/2/24 at 9:59 AM, the surveyor interviewed the US FOIA (b) (6) [redacted] in the presence of the survey team. He stated that he was not told he was responsible to notify the state Ombudsman's office of resident's emergency transfers. He further stated that he inferred this since the previous US FOIA (b) (6) had done so. The U.S. FOIA (b) stated that at past jobs, it was the US FOIA (b) (6) [redacted] responsibility. He stated that he found a binder from the facility's previous US FOIA (b) (6) that had records of notification to the resident or family regarding emergency transfers which she emailed to the state Ombudsman's	F 623	NJ Exec Order 26.4b1 [redacted] to the hospital with NJ Exec Order 26.4b1 [redacted]. The appropriate notification was sent to the residents NJ Exec Or [redacted] on NJ Exec Order 26.4b1 [redacted] electronically. The Actors Fund Home did not notify the Ombudsman's Office until NJ Exec Order 26.4b1 [redacted]. 2. During the survey it was determined that the facility was not in compliance with the regulation as it was reporting quarterly and not 30 days as required. As of 2/6/2024 that practice has been changed and the Director of Social Services will now report monthly as required. To ensure no other resident were impacted the Director of Social Worker reported all residents that were recently discharged from the facility to the Ombudsman's Office on 2/6/2024. 3. To ensure this practice does not happen again the facility has changed and updated its policy and procedure for transfers / discharges. The Director of Social Services will report all discharges to the Ombudsman's Office on the 1st of the month or the next business day. In addition, the completed matrix / roster downloaded from the Ombudsman's website will be completed and sent on a monthly basis. All social workers for the facility were all in-serviced and educated by the Director of Social Services on 2/8/2024. 4. This deficient practice will be monitored by the Administrator monthly to ensure that the facility remains compliant. The monthly notification and corresponding	

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F 623	Continued From page 4 office quarterly and he continued to do so. He stated that the purpose of notifying the state Ombudsman's office was to ensure that the facility was not sending residents out "just to get them out." On 2/2/24 at 2:48 PM, the survey team met with the U.S. FOIA (b)(6) [redacted] to discuss this concern. The U.S. FOIA (b)(6) stated that the facility had always sent the resident emergency transfer's information to the state Ombudsman's office on a quarterly basis. On 2/5/24 at approximately 9:30 AM, the U.S. FOIA (b)(6) provided the surveyor with the name and phone number for a representative of the Office of the Long-Term Care Ombudsman who he stated he spoke to regarding this concern. On 2/5/24 at 1:08 PM, the surveyor interviewed the US FOIA (b) (6) [redacted] from the Office of Long-Term Care Ombudsman via phone. She stated that she spoke to the U.S. FOIA (b)(6) on Friday related to the frequency to which the facility should have notified the office of resident emergency transfers. She stated that she educated the U.S. FOIA (b)(6) that moving forward, the facility should notify the office on a monthly basis. On 2/5/24 at 1:21 PM, the surveyor interviewed the U.S. FOIA (b) in the presence of the survey team. He confirmed that when he emailed the state Ombudsman's office resident emergency transfers, he sends the residents face sheet and each individual notice of transfer. Review of the facility policy "Emergency Transfer Notification" dated May 2017, included the	F 623	roster of residents will be included in the facility's QAPI plan and will be submitted to the Quality Assurance Committee to be reviewed quarterly.	

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F 623	Continued From page 5 following: -"CMS [Centers for Medicare and Medicaid Services] requires that copies of the NOTICE for temporary emergency transfer MUST also be sent to the Ombudsman." -"CMS states that notification to the Ombudsman MUST be sent by the facility, but allows that this notification can be made when practicable such as quarterly."	F 623		
F 640 SS=B	NJAC 8:39-5.1(a) Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.	F 640		2/6/24

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F 640	Continued From page 6 §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review, interviews and review of pertinent facility documents, it was determined that the facility failed to transmit the Minimum Data Set (MDS) assessments, a tool to facilitate the management of care, in a timely manner and in accordance with the Center's for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual. This deficient practice was identified for 2 of 2 residents, (Resident #13 and #74). The evidence was as follows: According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's	F 640	F640 ENCODING/ TRANSMITTING RESIDENT ASSESSMENTS CFR(s): 483.20 (f)(1)-(4) 1. Facility failed to transmit the MDS assessments in a timely manner and in accordance with the CMS RAI manual. Resident #13 - entry MDS was completed on [redacted] and was submitted on [redacted] Resident #74 - entry MDS was completed on [redacted] and was submitted on [redacted] Both residents have had been [redacted] from the facility.	

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F 640	Continued From page 7 Guide Version 1.17.1, October 2019 which included that an Entry (admission) MDS "must be transmitted within 14 days of the Event Date (date of admission). Resident #13: The surveyor reviewed the Entry MDS dated [NJ Exec Order 26]. Review of the "MDS Transmission Results Summary" dated [NJ Exec Order 26.4b] provided by the U.S. FOIA (b)(6)) revealed that the residents MDS should have been transmitted by [NJ Exec Order 26.4] but was not submitted unti [NJ Exec Order 26.4b] . Review of the undated "Final Validation Report" for Resident #13 provided by the [U.S. FOIA (b)(6)] revealed a "Warning" message "Record Submitted Late: The submission date is more than 14 days after ... entry tracking record ..." Resident #74: The surveyor reviewed the Entry MDS dated [NJ Exec Order 26.4b] Review of the "MDS Transmission Results Summary" dated [redacted] provided by the [U.S. FOIA (b)] revealed that the residents MDS should have been transmitted by [U.S. FOIA (b)(6)] but was not submitted unti [NJ Exec Order 26.4b] at 7:09 AM. Review of the undated "Final Validation Report" for Resident #74 provided by the [U.S. FOIA (b)], revealed a "Warning" message "Record Submitted Late: The submission date is more than 14 days after ... entry tracking record ..."	F 640	2. During this survey it was determined that although the MDS was completed on time in the facility software, it did not flow over to the IQIES side of the software. Which caused the facility to have late submissions. Although it was not showing as a missing assessment in our software, CMS never got the MDS's, therefore it was submitted late. To ensure that other residents MDS assessments were not outstanding the Director of Nursing and MDS Coordinator went through all the residents MDS assessments to ensure that all MDS's were submitted and accepted by CMS. 3. To ensure that this deficient practice does not happen the MDS Coordinator has changed the facility practice and will now submit all completed MDS's twice a week. At the time of submission the validation reports from CMS will be thoroughly reviewed and checked to make sure that all MDS's were submitted and accepted by CMS. 4. The Director of Nursing will monitor and perform a weekly audit of the validation reports from CMS to make sure the facility remains in compliance. In addition, the Director of Nursing will monitor the IQIES website and facility software to check for the MDS missing assessment report. All of these findings will be reported by the Director of Nursing to the Quality Assurance Committee on a quarterly basis.	

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F 640	Continued From page 8 On 2/02/24 at 1:43 PM, the surveyor interviewed the [redacted] in presence of the survey team. She stated that the [redacted] completed the MDS and that she transmitted the MDS data to CMS. She stated that she transmitted data in a batch every other Friday. The [redacted] acknowledged and stated that "maybe I am late" since she did not transmit data based on the residents individual MDS schedule. On 2/05/24 at 12:29 PM, the surveyor interviewed the [redacted] in the presence of the [redacted] and survey team. The [redacted] stated that she needed to complete Entry MDS's within seven days of admission but usually completed an Entry MDS on the day of admission. She further stated that two weeks after the MDS completion date, the [redacted] should transmit the MDS. The surveyor reviewed the "MDS Transmission Results Summary" with the [redacted] She acknowledged that the "Transmit by" date revealed the date the MDS should have been transmitted and the "Status Date" was the date the MDS was actually transmitted. The [redacted] also stated that she communicated to the [redacted] verbally as to when MDS's were completed. On 2/05/24 at 12:41 PM, the [redacted] acknowledged that she focused on MDS's that were rejected and not on those that were late. Both the [redacted] and the [redacted] acknowledged that the "Final Validation Report" would indicate a warning message if there was a late transmission. On 2/05/24 at 12:44 PM, the [redacted] acknowledged that she did not know about these late transmissions prior to surveyor inquiry. The [redacted] reviewed the reports in the presence of the	F 640		

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F 640	Continued From page 9 surveyor and acknowledged that the Entry MDS's for both Resident #13 and #74 were transmitted late, . She also acknowledged that each resident had a different MDS schedule, and they should have been transmitted more frequently. Review of the facility policy "MDS" dated 10/2023, included that the RAI coordinator will ensure that each MDS is completed and transmitted within the regulation guidelines. It further included that an MDS should be transmitted within 14 days after the completion date.	F 640		
F 732 SS=D	N.J.A.C. 8:39-11.2(e)(3) Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.	F 732		2/6/24

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F 732	Continued From page 10 (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of pertinent facility documents, it was determined that the facility failed to accurately post staffing information to include the total number and actual hours worked for licensed and unlicensed staff responsible for resident care. This deficient practice was evidenced by the following: On 01/29/24 at 01:22 PM, the surveyor observed the nurse staffing information posted at the nursing station on the South unit on a large visible monitor as follows: -Census Hours -January 29th, 2024 -Census: 93 -7am-3 pm Shift; RN (Registered Nurse)/LPN (Licensed Practical Nurse) Hous (hours): 48; CNA (Certified Nursing Aide) Hours:128 -3 pm-11 pm Shift; RN/LPN Hours: 40; CNA	F 732	F732 POSTED NURSE STAFFING INFORMATION CFR(S): 483.35(G)(1)-(4) 1. The facility failed to accurately post staffing information to include total number and actual hours worked for licensed staff responsible for resident care. On 1/29/23, 1/30/23, 1/31/23 and 2/1/23, the surveyor noted that our staffing information posted on our digital signage for all 3 shifts was incomplete and not meeting all elements of the posting criteria as part of the regulation. 2. On 2/6/24, the Director of Nursing reviewed the above regulations thoroughly and noted that the number of licensed staff (RN, LPN, CNA) was not properly documented. The digital signage and postings were revised to reflect the	

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F 732	Continued From page 11 Hours: 88 -11 pm-7am Shift; RN/LPN Hours: 40 CNA Hours: 64 On 01/30/24 at 10:05 AM, the surveyor observed the following nurse staffing information posted on the monitor on the South unit as follows: -Census Hours -January 30th, 2024 -Census: 92 -7 am-3 pm Shift; RN/LPN; Hous: 48; CNA Hours: 136 -3 pm-11 pm Shift; RN/LPN Hours: 40; CNA Hours: 88 -11 pm-7 am Shift RN/LPN Hours:40; CNA Hours: 64 On 01/31/24 at 09:50 AM, the surveyor observed the following nurse staffing information posted on the monitor on the South unit as follows: -Census Hours -January 31st, 2024 -Census: 90 -7 am-3 pm Shift; RN/LPN Hous: 48; CNA Hours: 104 -3pm-11pm Shift; RN/LPN Hours: 40; CNA Hours:104 -11pm-7am Shift; RN/LPN Hours:40; CNA Hours: 64 On 02/01/24 at 12:14PM, the surveyor interviewed the U.S. FOIA (b)(6) in reference to the daily staffing and posting of the nursing staffing information. The U.S. FOIA (b)(6) explained that the purpose of the nurse staffing posting was to account for the number of staff in the building. She stated that the U.S. FOIA (b)(6) was responsible to post the nurse staffing information daily. She	F 732	required information needed for nurse staffing information. This posting will be able to be viewed by all the residents on all units, families and visitors coming to the Actors Fund Home. All US FOIA (b) (6) and US FOIA (b) (6) were in serviced and educated regarding this change on 2/6/24. 3. To ensure that this deficient practice does not happen the digital signage is done every morning by the unit secretary. There is a unit secretary is scheduled daily 7 days a week. In the event that the unit secretary is not available, the nursing supervisor will complete task and validate the information. The nursing supervisor/ Director of Nursing will confirm and validate posting on a daily basis and per shift. The daily posting will be updated and revised if there are any changes in the staffing. In addition, the Unit secretary/ nursing supervisor will post a copy of the staffing in the entrance vestibule which is a highly visible area for all residents, families and visitors to see. The postings will be saved in an electronic file for future reference. 4. This deficient practice will be included in the facility□s Quality Assurance Performance Improvement plan which meets quarterly. The Unit secretary/ Director of Nursing will provide monthly reports to the Quality Assurance committee. The Director of Nursing/ Nursing Supervisor/ Quality Coordinator will monitor this posting on a daily basis to ensure compliance for 30 days. At that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315377	A. BUILDING _____ B. WING _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTORS FUND HOME, THE	**175 WEST HUDSON AVE ENGLEWOOD, NJ 07631**

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F 732	Continued From page 12 further explained that the required information to be posted was, "how many nurses were in the building, CNA's, administration staff and the resident census." On 02/01/24 at 12:34 PM, the surveyor interviewed the U.S. FOIA (b) regarding the information posted on the nurse staffing report. The U.S. FOIA (b) explained that the purpose of the nurse staffing report was to inform the residents and family of the staffing ratios. She explained that the facility used "regulations" to determine the staffing levels. The U.S. FOIA (b) stated that the current date, census, CNA hours and RN/LPN hours per shift should be posted on the nurse staffing report. She stated that the RN/LPN hours were combined on the nurse staff report, however, on the daily staffing sheets, the RN/LPNs were identified. The U.S. FOIA (b) stated, "that it was the US FOIA s responsibility to update and post the nurse staffing information which was reviewed by her and the US FOIA (b) (6) to ensure accuracy of the staffing notification." On 02/05/24 at 9:47 AM, the surveyor interviewed the U.S. FOIA (b)(6) that completes the nurse staffing report, who stated that he obtains the information to enter on the nurse staffing report by counting who was on the daily staffing book for all shifts. He then obtains the census from each unit, and then tallies the census (from every unit), the nurses and the CNA's and calculates it." He explained that he was shown how to complete the nurse staffing report from the previous US FOIA . Review of the facility policy titled "Facility Census and Staffing Ratio" dated 12/1/2021 and revised 5/8/23, revealed Procedure: the facility	F 732	point it will be monitored weekly for the next 3 months and reported to the Quality Assurance Committee by the Director of Nursing/ Nursing Supervisor.	

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F 732	Continued From page 13 documents the unit clerk will post the following on the digital signage, located in the NH (nursing home) Nursing station daily in the morning: (a.) date, (b) total current census of the day for the BOH (Broadway and Hudson), East, South and SP Unit, (c) total number of RN and LPN hours for each shift, (d) total number of hours of CNAs on each shift, (e) names of nurses on duty on each shift.	F 732		
F 761 SS=D	NJAC 8:39-41.2(c) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 761		2/6/24

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F 761	Continued From page 14 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store, and dispose of medications in 1 of 5 medication carts inspected. This deficient practice was evidenced by the following: On 02/1/24 at 11:20 AM, the surveyor inspected the Broadway unit medication cart in the presence of the Licensed Practical Nurse (LPN). The surveyor observed an unopened bottle of Xalatan eye drops (medication for pressure in the eye) stored in the medication cart and an opened Breo inhaler (medication for breathing) with an opened date of 12/15/23 that was expired. The surveyor interviewed the LPN who stated that an unopened bottle of Xalatan eye drops should have been stored in the refrigerator and once removed from the refrigerator it should have been dated. LPN also acknowledge that the Breo inhaler was expired and should have been removed from the medication cart. A review of the Manufacturer's Specifications for the following medications revealed the following: 1. Unopened Xalatan eye drops should be stored in the refrigerator. 2. Xalatan stored at room temperature has an expiration date of 42-days. 3. Breo inhaler once opened has an expiration date of 42-days. On 2/2/24 at 3:00 PM, the surveyor discussed the	F 761	F761 LABEL/STORE DRUGS AND BIOLOGICALS CFR(S): 483.45(G)(H)(1)(2) 1. The facility failed to properly label, store and dispose of medications in 1 of 5 medication carts inspected by the State surveyor. On 2/1/24, it was noted by the State surveyor while inspecting the BOH medication cart that Xalatan eye drops unopened was in the medication cart vs in the fridge. Breo Ellipta inhaler was also noted opened with a date 12/15/23 (which is only good for 6 weeks), which was supposed to be discarded on 1/29/24. As a result of these findings, both medication were discarded. All medications that were in medication or treatment carts throughout the facility were checked on 2/2/24. 2. The facility ensured that all medications were properly dated when opened and within the manufacturer's expiration of use. All LPN's & RN's were in-service / educated regarding this on 2/6/24 by the Director Of Nursing. 3. To ensure that this deficient practice would not recur, medication and treatment cart checks will be done by the nurse on duty per shift for the next 6 months and will complete the medication cart check form. In addition, the facilities consulting pharmacist NJ Exec Order 26.4b1 will check each medication cart monthly during their visit	

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F 761	Continued From page 15 above observations and findings with the U.S. FOIA (b)(6)) and the U.S. FOIA (b)(6) There was no additional information provided. A review of the facility's policy titled Storage of Medications dated 3/19/23 and provided by the U.S. FOIA (b) included the following: "H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal." Under Temperature: "D. Medications requiring refrigeration are kept in a refrigerator at temperatures between 35 F (2 C) and 46 F (8 C) with a thermometer to allow temperature monitoring. All other medications should be stored in accordance with manufacturer label and instructions." Under Expiration Dating: "D. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, blood sugar testing solution and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency." "G. The nurse will check the expiration date of each medication before administering it." "H. No expired medication will be administered to	F 761	to ensure the facility is in compliance with opening and dating of medications. 4. This will be monitored and included in the facility's Quality Assurance Performance Improvement (QAPI) plan which meets quarterly. The Pharmacy Consultant NJ Exec Order 26.4b1 will provide the facility monthly reports and will be reviewed by the Director of Nursing and be reported to the Quality Assurance Committee. The facility will monitor the dates of opened medications on a monthly basis by the nursing supervisor to ensure compliance for 12 months. The reports will be submitted to the Quality Assurance Committee on a quarterly basis.	

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F 761	Continued From page 16 a resident." "I. All expired medications will be removed from active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner." NJAC: 8:39-29.4 (a) (h) (d)	F 761		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315377 Y1	A. Building B. Wing Y2	2/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTORS FUND HOME, THE	175 WEST HUDSON AVE ENGLEWOOD, NJ 07631

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0623	Correction	ID Prefix F0640	Correction	ID Prefix F0732	Correction
Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	02/08/2024	LSC	02/06/2024	LSC	02/06/2024
ID Prefix F0761	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/06/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/5/2024	☐ YES ☐ NO

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 01/29/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Health Care Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/29/24 and was found not to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The Actors Fund Home has two buildings. The first building labeled the Sub-Acute/Shubert building was constructed in 2017 according to staff. The building is two stories, with the certified sub-acute unit on the first floor. The building was constructed of Type I building construction (222), concrete block bearing walls, concrete flooring, and steel deck roofing with steel supports with a fire resistive coating on all steel. The building is labeled as the 300 unit and is served by a 350-kilowatt (KW) diesel stand by generator. The second building is the nursing center and was also constructed of Type I building construction (222). It has two floors with a lower-level certified dementia wing built in 1993. The building is two stories with concrete flooring, steel deck roofing with steel supports and a fire	K 000		

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

Electronically Signed | 02/14/2024

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

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K 000	Continued From page 1 resistive coating on all steel and block bearing walls. The facility has an 80-kilowatt (KW) diesel generator. The facility does not know what percentage of load each generator is at under full load. The facility has 11 smoke compartments and a census of 93.	K 000		
K 341 SS=E	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to ensure two of 165 photo electric smoke detectors were greater than 36 inches from ceiling air diffusers in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 29.8.3.4.(6). This deficient practice had the potential to affect 12 residents.	K 341	K 341 Fire Alarm System The Actors Fund Home will ensure that the facility is compliant with all Fire Codes. The smoke detectors that was located less than 36 inches from the air diffuser were relocated to be at least 36 inches and now in code.	2/7/24

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K 341	Continued From page 2 Findings include: An observation on 01/29/24 at 10:50 AM of a smoke detector in the corridor near bedroom 101 revealed the smoke detector was 11 inches from a heating and cooling air diffuser as measured by the US FOIA (b) (6) . An observation on 01/29/24 at 11:00 AM of a smoke detector, located in the pantry on the first floor of the nursing center near the maintenance room revealed the smoke detector was 11 inches from a heating and cooling air diffuser as measured by the U.S. FOIA (b)(6) . A review of the facility's contractor report titled "Fire Alarm Inspection Report," dated 04/05/23 and 10/03/23 revealed no documented evidence the smoke detectors proximity to the air diffusers were noted. During an interview at the time of each observation, the U.S. FOIA (b)(6) verified the distance of the smoke detector from the air diffuser. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 341	The detector by room 101 was relocated to be at least 36 inches from the diffuser on 1/31/2024 The detector located by the pantry on the first floor was relocated to be at least 36 inches from the diffuser on 1/31/24 To ensure this condition did not exist in other areas of the facility the Director of Maintenance walked the entire facility to make sure there were no other smoke detectors that were less than 36 inches from an air diffuser. To make sure this does not happen again the Director of Maintenance will do an annual walk through of the facility. The annual findings will be reported to the Quality Assurance Committee on an annual basis.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		2/6/24

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K 345	Continued From page 3 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to complete a smoke detection sensitivity test for all 165 photo electric smoke detectors in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 93 residents. Findings include: A review of the facility's untitled fire safety records, located in a white binder under the "Fire Alarm" tab provided by the U.S. FOIA (b)(6), revealed the most recent fire alarm inspection reports dated 04/03/23 and 10/03/23 did not include a smoke detection sensitivity test. An observation on 01/29/24 from 10:45 AM to 12:00 PM revealed the facility had smoke detection in all corridors every 30 feet. The facility did not have a smart fire alarm system to continuously monitor for sensitivity. During an interview on 01/29/24 at 2:30 PM, the U.S. FOIA (b)(6) indicated the facility did not have a smoke detector sensitivity test completed during the past two inspections. The U.S. FOIA (b)(6) stated the facility alarm system was not a smart system and was not capable of monitoring sensitivity for its smoke detectors continuously. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	K 345 Fire Alarm System Testing The Actors Fund Home will ensure that it is compliant with all Fire Codes. On Tuesday 1/26/2024 a technician from NJ Exec Order 26.4b1, fire alarm system, came to the facility to pull the sensitivity reports for the smoke detectors throughout the facility. However the report is dated 1/30/2024. To ensure that this does not happen again the facility has asked NJ Exec Order 26.4b1 to include the sensitivity report of all smoke detectors when it completes its semi-annual testing. The Director of Maintenance will make sure that that sensitivity report is done and included in the Johnson report when they come for testing. This will be monitored and reported to the Quality Assurance Committee on a monthly basis.	
K 347 SS=E	Smoke Detection	K 347		2/16/24

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ACTORS FUND HOME, THE	**175 WEST HUDSON AVE** **ENGLEWOOD, NJ 07631**

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K 347	Continued From page 4 CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure one area use, open to the corridor, had smoke detection in accordance with NFPA 101 (2012 edition) section 19.3.6.1. (C). The deficient practice had the potential to affect 12 residents. Findings include: An observation on 01/29/24 at 11:05 AM of a lounge area in the nursing center's corridor near bedroom 116 revealed the room was 200 square feet and the room contained two chairs and one couch and lacked smoke detection. The room was open to the corridor and lacked walls and doors to prevent the passage of smoke/fire from the room to the exit access corridor. One resident was seated in the use area at the time of the observation. A review of the contractor form titled "Fire Alarm Inspection Reports," dated 04/05/23 and 10/03/23 revealed no reference to an open use area or lack of smoke detection. During an interview at the time of the observation, the U.S. FOIA (b)(6) verified that the open use area lacked smoke detection. NJAC 8:39-31.1(c), 31.2(e)	K 347	K 347 Smoke Detection System The Actors Fund Home will ensure that it is compliant with all Fire Codes. The Actors Fund Home added a new smoke detector into the lounge area that was not in compliance. On Thursday 2/15/2024 the facilities Electrician was on site and installed the new smoke detector in the lounge space. On Friday 2/16/2024 NJ Exec Order 26.4b1 (alarm system vendor) was onsite and programmed the new device into the panel and was tested and left in working order. To ensure that there were no other areas of concern throughout the facility the Director of Maintenance walked the rest of the facility to make sure no other areas did not need an additional detector. The Director of Maintenance will do an annual walk through to make sure that there are no other areas not in compliance. The Director of Maintenance will make sure that annual report is submitted to the Quality Assurance Committee to be reviewed at its quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315377	A. BUILDING **01** B. WING _____	**02/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTORS FUND HOME, THE	**175 WEST HUDSON AVE** **ENGLEWOOD, NJ 07631**

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K 347	Continued From page 5 NFPA 70, 72	K 347		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)	K 918		2/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315377	A. BUILDING 01 B. WING _____	02/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTORS FUND HOME, THE	175 WEST HUDSON AVE ENGLEWOOD, NJ 07631

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K 918	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure the 80 KW (kilowatt) diesel generator serving the nursing center and the 350 KW diesel generator serving the sub-acute care unit were maintained in accordance with NFPA 110 (2010 edition) section 8.3.4. and 8.4.5.9.1. This deficient practice had the potential to affect the safety of all 93 residents. Findings include: An observation on 01/29/24 at 11:30 AM of the 80 KW generator revealed the generator was positioned indoors in the boiler room and the 350 KW diesel generator was located outside. A review of the facility's untitled fire safety records, located in a white binder provided by the U.S. FOIA (b)(6), revealed no documented evidence that the facility ensured load bank testing at 30% or greater were completed for each of the generators. During an interview on 01/29/24 at 2:15 PM, the U.S. FOIA (b)(6) and US FOIA (b) (6) stated the facility had not ensured load bank testing was completed since the generators were installed. The 80 KW generator was installed in 1993 and the 350 KW generator was installed in 2017. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	K918 Electrical System Maintenance and Testing The Actors Fund Home will ensure that it is compliant with all testing of essential electrical systems On 2/7/2024 NJ Exec Order 26.4b1 the Facilities generator company was on site conducting the Load testing for the facilities 3 generators. After NJ Exec Ord did the testing it was determined that none of the facilities 3 generators required load bank testing as they all exceeded the code. All 3 generators including the 80 KW & the 350 KW all run greater than 30 %. To ensure that this is not an issue in the future the Director of Maintenance will keep a copy of the testing that was completed in the survey binder for other surveys.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315377 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/26/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTORS FUND HOME, THE	175 WEST HUDSON AVE ENGLEWOOD, NJ 07631

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0341	02/07/2024	LSC K0345	02/06/2024	LSC K0347	02/16/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	02/14/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO