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

PRINTED: 03/04/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		315358	B. WING		C 08/02/2024	
	ROVIDER OR SUPPLIER VIEW NURSING AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 235 DOLPHIN AVE NORTHFIELD, NJ 08225	1 00/02/2024	
0/0.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	- 10	PROVIDER'S PLAN OF CORRECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION	
F 000	INITIAL COMMENTS		F 00	00		
	Complaint #: NJ0017	75651				
	Survey Dates: 08/02/	24				
	Census: 106					
	Sample Size: 4					
	42 CFR PART 483, S	OT IN SUBSTANTIAL THE REQUIREMENTS OF UBPART B, FOR LONG TIES BASED ON THIS				
F 559 SS=D		f Room/Roommate Change -(6)	F 5	59	8/30/24	
	or her spouse when n	ht to share a room with his narried residents live in the n spouses consent to the				
	or her roommate of cl when both residents I	ht to share a room with his hoice when practicable, ive in the same facility and ht to the arrangement.				
	including the reason f resident's room or roo changed.	ht to receive written notice, for the change, before the ommate in the facility is				
	by: COMPLAINT #NJ00 ⁻ Based on observatior	175651 n, interview, and record		CRITERIA 1 The administrator met with resident #1 and resident #2 and explained to resident		
	review, on 08/02/24, i	it was determined that the a resident in writing of a		#1 and resident #2 the plan of correcti Moving forward, the staff will ensure the	on.	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE .	TITLE	(X6) DATE	

08/24/2024 **Electronically Signed**

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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER-AND PLAN OF CORRECTION COMPLETED A. BUILDING 315358 R WING 08/02/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 235 DOLPHIN AVE MEADOWVIEW NURSING AND REHABILITATION CENTER NORTHFIELD, NJ 08225 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 559 Continued From page 1 F 559 resident room change for 2 of 2 residents any resident being moved will receive (Resident #1 and Resident #2). written notice including the reason for the change, before any room change. This deficient practice was identified and was evidenced by the following: CRITERIA 2 All residents have the potential to be 1). On 08/02/24 at 11:45 A.M., the surveyor affected by this deficient practice. The Administrator met with 10 NIEXO observed Resident #1 awake in bed, watching and television. The surveyor asked how long the residents. The Administrator resident had been in this room and the resident educated and reminded the 10 stated that he/she had been there for about residents of their right to receive . The resident stated that the U.S. FOIA (D) (b) written notice before they move to another [of the previous unit] and the U.S. FOIA (b) (6) room. The residents understood. informed his/her that the resident was moving **CRITERIA 3** due to, "something to do with resident further stated that he/she had not The US FOIA (b)(6) received anything in writing prior to the move. Social Review of Resident #1's Admission Record (AR) Workers, and Nurse Supervisors face sheet (an admission summary) revealed that completed the in-service "Room Change: the resident was admitted to the facility with In House." Their responsibilities are not diagnoses that included, but were not limited to: limited to ensuring the residents have the NJ Ex Order 26.4(b)(1) right to receive written notice, including the reason for the change, before the resident's room in the facility is changed. Review of Resident #1's annual Minimum Data Set (MDS), an assessment tool to facilitate the CRITERIA 4 management of care, dated The Director of Social Services will audit reflected that the resident had a brief interview for mental room changes weekly for 6 months. status (BIMS) score of out of 15, which These audits will be reviewed by the indicated that the resident was NJ Ex Order 26.4(b)(1 Administrator. For 2 quarters, the results will be reported and reviewed in the Review of Resident #1's progress notes (PN) quarterly QAPI (Quality Assurance revealed a social worker note, dated Performance Improvement) meeting for 12:04 P.M., that indicated that the resident was continued compliance and or any transferred to another room and that written recommendations by the QAPI team. notification was provided. A further review of the electronic medical record did not reveal evidence of the required written notification of the room

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		(X3) DATE SURVEY COMPLETED			
		315358	B. WING			C 08/02/2024		
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW NURSING AND REHABILITATION CENTER				235	EET ADDRESS, CITY, STATE, ZIP CODE DOLPHIN AVE RTHFIELD, NJ 08225	<u> US/</u>	VEIZUZT	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
F 559	observed Resident # wheelchair, watching asked how long the room and the resident maybe NEXOTOGET 28-4(b)(1) ." U.S. FOIA (b) (6) informed was NEXOTOGET 28-4(b)(1) and resident further stated received anything in varieties and the resident further stated revealed that the resificiality with diagnoses limited to: NJ EX OF Indication with the resident had a brief in (BIMS) score of the resident was NJ EX Review of Resident for the resident was NJ EX Review of Resident for the resident was not put the electronic medical evidence of the requirement of the resident should be represented by the resident should be resident should be represented by the resident should be repre	:33 A.M., the surveyor 2 seated at the bedside in a television. The surveyor esident had been in this at stated, "Sometime in The resident stated that the ed his/her that the resident dineeded to be moved. The dithat he/she had not writing prior to the move. E2's Admission Record (AR) dent was re-admitted to the statat included but were not resident dineeded to the statat included but were not reflected that the nerview for mental status at of 15, which indicated that rooms and that written rovided. A further review of all record did not reveal red written notification of the with the surveyor on 08/02/24	F	559				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		315358	B. WING_			C 08/02/2024	
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 235 DOLPHIN AVE NORTHFIELD, NJ 08225		00/02/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 559	interview, at 2:10 P.M surveyor, the Surveyor, the Surveyor, the Surveyor re "SUBJECT: Room Chestated that residents informed them of the provided to the survey Resident #2. During an interview wat 1:30 P.M., the U.S she informed Resident the day of the move.	I., in the presence of the viewed a facility form titled, nange, In-house." The received the form which room changes; no form was yor for Resident #1 nor with the surveyor on 08/02/24 FOIA (b) (6) stated that not #1 of the room change on She further stated that she resident with a written	FS	559			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED			
			_		С		
	060101			B. WING		08/02/2024	
NAME OF D	ROVIDER OR SUPPLIER		STREET AND	RESS, CITY, STA	TE ZIR CODE		
NAME OF T	NOVIDEN ON 301 1 EIEN		235 DOLPH	, ,	11E, 211 GODE		
MEADOW	VIEW NURSING AND RE	HABILITATION CEN		LD, NJ 08225			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
S 000	Initial Comments			S 000			
	8:39, standards for lic Facilities. The facility Correction, including a deficiency and ensure implemented. Failure result in enforcement	Jersey Administrative of the consure of Long Term Comust submit a Plan of a completion date for eathat the plan is to correct deficiencies action in accordance when Jersey Administratives	care ach may vith				
S 560	8:39-5.1(a) Mandator	y Access to Care		S 560			8/30/24
	(a) The facility shall confederal, State, and longer regulations.						
	by: Based on review of perdocumentation, it was failed to ensure staffir maintain the required ratios as mandated by 2 of 14 day shifts. The evidenced by the following th	determined that the far ag ratios were met to minimum staff-to-residy the state of New Jerse deficient practice was awing: Department of Healed 01/28/2021, "Complience Statutes Annotate am staffing requirement ated the New Jersey law P.L. 2020 c 112, 0:13-18 (the Act), whice	ent ey for th ance ed) ts for		CRITERIA 1 The facility will ensure all avenues and resources are exhausted. The facility implemented immediate on the spot interview for qualified candidates. The facility advertised for the following positions: registered nurse, licensed practical nurse, and certified nursing assistant. CRITERIA 2 All residents have the potential to be affected by this deficient practice. Fac will follow the staffing plan by utilizing overtime, mandatory overtime, and	ility	
	established minimum	staffing requirements i	n		agency staff to meet minimum staffing		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

08/24/24

PRINTED: 03/04/2025 FORM APPROVED

New Jersey Department of Health

NAME OF PROVIDER OR SUPPLIER MEADOWNIEW NURSING AND REHABILITATION CEN (MA) ID (CACH DEPCICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 560 Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be clikas and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member shall sign in to work as a certified nurse aide and perform CNA duties. The surveyor requested staffing for the weeks of 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -07/14/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. STREET ADDRESS, CITY, STATE, ZIP CODE 235 DOL PHIN AVE NORTHELD, NJ 08225 D PROVIDER'S PLAN OF CORRECTION (CACH ON RECCTION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROP	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
MEADOWVIEW NURSING AND REHABILITATION CEN WEADOWVIEW NURSING AND REHABILITATION CEN SUMMARY STATEMENT OF DEFICIENCES (X4) ID (X4) ID (X4) ID (X5) DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) S 560 Continued From page 1 nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the hight shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -07/14/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. -07/27/24 had 10 CNAs for 104 residents on the						С	
Soluminary Statement of Deficiencies Deficiency Must be Preceded by Full REGULATORY OR LISC IDENTIFYING INFORMATION) Display Deficiency Must be Preceded by Full REGULATORY OR LISC IDENTIFYING INFORMATION) Display Deficiency Must be Preceded by Full REGULATORY OR LISC IDENTIFYING INFORMATION) Display Deficiency Must be Preceded by Full REGULATORY OR LISC IDENTIFYING INFORMATION) Display Deficiency Must be Preceded by Full Regulatory or Lisc IDENTIFYING INFORMATION) Display Deficiency Must be preceded by Full Regulatory or Lisc IDENTIFYING INFORMATION) Display Deficiency Must be preceded by Full Regulatory or Lisc IDENTIFYING INFORMATION) Display Deficiency Must be preceded by Full Regulatory Deficiency Must be preceded by Missions of the Regulatory Deficiency Must be preceded by Preceded by Preceded by Regulatory Deficiency Must be preceded by Deficiency Deficiency Must be preceded by Deficiency			060101	B. WING		08/02/2024	
(X4) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FILL PREFIX TAG (EACH DEFICIENCY) S 560 Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member shall be signed into work as a certified nurse aide duties: and one direct care staff member shall sign in to work as a CNA and perform CNA duties. One CNA duties. One Critical A to 7/27/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on the day shift, required at least 13 CNAs. ONE The FIELD, NJ 08225 ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) S 560 Continued From page 1 CRITERIA 3 Facility will continue to advertise for new hires. Facility will follow the staffing plan by utilizing overtime, mandatory overtime, and agency staff to meet minimum staffing requirements. Facility will curtail admissions of new residents if staffing needs cannot consistently be met. CRITERIA 3 Facility will continue to advertise for new hires. Facility will follow the staffing plan by utilizing overtime, mandatory overtime, and agency staff to meet minimum staffing requirements. Facility will curtail admissions of new residents if staffing needs cannot consistently be met. CRITERIA 4 A review of staffing level will be conducted by the Director of Nursing 5 days a week and review of the weekend staffing level to ensure compliance with the state minimum staffing level to ensure compliance with the state minimum staffing level will be discussed in the daily management meeting. For 2 quarters, the results will be reported and reviewed in the quarterty QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team.	NAME OF P	ROVIDER OR SUPPLIER		, ,	TE, ZIP CODE		
Summary Statement of Deficiencies Fach Deficiency Must be Preceded by Pull Redulatory Must be Preceded by Pull Redulatory or Iso (EACH CORRECTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DATE	MEADOW	VIEW NURSING AND RE	HABILITATION CEN				
nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -07/14/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. The complex of the day shift to divertise for new hires. Facility will continue to advertise for lew hires. Facility will continue to advertise for lew hires. Facility will continue to advertise for new hires. Facility will continue to advertise for new hires. Facility will continue to advertise for lew titilizing overtime, and agency staff to meet minimum staffing requirements. Facility will curtail admissions of new residents if staffing needs cannot consistently be	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE COMPLETE	Ē
One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for the weeks of 07/14/2024 to 07/27/2024, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -07/14/24 had 10 CNAs for 105 residents on the day shift, required at least 13 CNAs. CRITERIA 3 Facility will continue to advertise for new hires. Facility will continue to advertise for new hires. Facility will follow the staffing plan by utilizing overtime, mandatory overtime, and agency staff to meet minimum staffing requirements. Facility will continue to advertise for new hires. Facility will follow the staffing plan by utilizing overtime, mandatory overtime, mandator	S 560	Continued From page	e 1	S 560			
	S 560	nursing homes. The f effective on 02/01/202 One Certified Nurse A residents for the day a member to every 10 r shift, provided that no shall be CNAs and eable signed into work a shall perform nurse a care staff member to night shift, provided the member shall sign in perform CNA duties. The surveyor request 07/14/2024 to 07/27/2 deficient in CNA staffiday shifts as follows: -07/14/24 had 10 CNA day shift, required at 1-07/27/24 had 10 CNA	ollowing ratio (s) were 21: Aide (CNA) to every eight shift. One direct care staff residents for the evening of fewer of all staff members and direct staff member shall as a certified nurse aide and ide duties: and one direct every 14 residents for the nat each direct care staff to work as a CNA and ed staffing for the weeks of 2024, the facility was ng for residents on 2 of 14 As for 105 residents on the least 13 CNAs. As for 104 residents on the	S 560	CRITERIA 3 Facility will continue to advertise for n hires. Facility will follow the staffing pl utilizing overtime, mandatory overtime and agency staff to meet minimum starequirements. Facility will curtail admissions of new residents if staffing needs cannot consistently be met. CRITERIA 4 A review of staffing level will be conduby the Director of Nursing 5 days a weand review of the weekend staffing levensure compliance with the state minimum staffing level required for eashift. The review of state minimum staffits, I he review of state minimum staffits level will be discussed in the daily management meeting. For 2 quarters results will be reported and reviewed quarterly QAPI (Quality Assurance Performance Improvement) meeting f continued compliance and or any	an by e, affing deted eek vel to ch affing the n the	

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PROVIDEI				TRUCTION				DATE C	F REVISIT
IDENTIFIC 315358	ATION N	UMBER	A. Building B. Wing					_{Y2} 9/27/20)24 _{Y3}
NAME OF FACILITY						STREET ADDRESS, CIT	Y. STATE. ZIP CODE	1	
MEADOWVIEW NURSING AND REHABILITATION				CENTER		235 DOLPHIN AVE	.,,		
						NORTHFIELD, NJ 08225	i		
program, corrected	to show and the number	those d date su and the	oy a qualified State surveyo leficiencies previously repo ich corrective action was a i identification prefix code p	orted on the CMS	S-2567, Staten ach deficiency	nent of Deficiencies and should be fully identifie	Plan of Correction, d using either the re	that have been egulation or LSC	
ITEM DATE		ITEM		DATE	ITEM		DATE		
Y4			Y5	Y4		Y5	Y4		Y5
ID Prefix	F0559		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg.#	483.10(e	e)(4)-(6)	Completed	Reg. #		Completed	Reg. #		Completed
LSC			08/30/2024	LSC			LSC		-
ID Prefix			Correction	ID Prefix		Correction	ID Prefix		Correction
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REVIEWEI STATE AG			REVIEWED BY (INITIALS)	DATE	SIGNATUR	RE OF SURVEYOR		DATE	
REVIEWE	D BY		REVIEWED BY (INITIALS)	DATE	TITLE			DATE	
FOLLOWUP TO SURVEY COMPLETED ON 8/2/2024					RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN		DF YE	s 🔲 no	

STATE FORM: REVISIT REPORT									
PROVIDER / SUPPLIER / CLIA		STRUCTION				DATE C	F REVISIT		
060101	A. Building B. Wing					9/27/20)24 _{Y3}		
NAME OF FACILITY				STREET ADDRESS, CIT	Y, STATE, ZIP CODE	•			
MEADOWVIEW NURSING	AND REHABILITATION	I CENTER		235 DOLPHIN AVE	_				
				NORTHFIELD, NJ 08225	5				
This report is completed by corrective action was according identification prefix code prereport form).	nplished. Each deficien	cy should be fully	identified usi	ng either the regulation	or LSC provision nu	ımber and the			
ITEM DA		ITEM		DATE	ITEM		DATE		
Y4	Y5	Y4		Y5	Y4		Y5		
ID Prefix S0560	Correction	ID Prefix		Correction	ID Prefix		Correction		
8:39-5.1(a) Reg. #	Completed	Reg. #		Completed	Reg. #		Completed		
LSC	08/30/2024	LSC —		Completed	LSC		- Completed		
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ID Prefix	Correction	ID Prefix		Correction	ID Prefix		Correction		
Reg. #	Completed	Reg. #		Completed	Reg.#		Completed		
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	REVIEWED BY (INITIALS)	DATE	TITLE			DATE			
FOLLOWUP TO SURVEY COM			RRECTED DEFICIENCIES ENCIES (CMS-2567) SEN			s 🗆 NO			

Page 1 of 1 EVENT ID: IDL612

YES NO

8/2/2024