STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315358	A. BUILDING _____ B. WING _____	C 08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	**235 DOLPHIN AVE NORTHFIELD, NJ 08225**

(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 Complaint #: NJ00175651 Survey Dates: 08/02/24 Census: 106 Sample Size: 4 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: COMPLAINT #NJ00175651 Based on observation, interview, and record review, on 08/02/24, it was determined that the facility failed to notify a resident in writing of a	F 559	CRITERIA 1 The administrator met with resident #1 and resident #2 and explained to resident #1 and resident #2 the plan of correction. Moving forward, the staff will ensure that	8/30/24

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

Electronically Signed | 08/24/2024

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F 559	Continued From page 1 resident room change for 2 of 2 residents (Resident #1 and Resident #2). This deficient practice was identified and was evidenced by the following: 1). On 08/02/24 at 11:45 A.M., the surveyor observed Resident #1 awake in bed, watching television. The surveyor asked how long the resident had been in this room and the resident stated that he/she had been there for about [redacted]. The resident stated that the [redacted] [of the previous unit] and the [redacted] informed his/her that the resident was moving due to, "something to do with [redacted]." The resident further stated that he/she had not received anything in writing prior to the move. Review of Resident #1's Admission Record (AR) face sheet (an admission summary) revealed that the resident was admitted to the facility with diagnoses that included, but were not limited to: [redacted], and [redacted]. Review of Resident #1's annual Minimum Data Set (MDS), an assessment tool to facilitate the management of care, dated [redacted] reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated that the resident was [redacted] Review of Resident #1's progress notes (PN) revealed a social worker note, dated [redacted] at 12:04 P.M., that indicated that the resident was transferred to another room and that written notification was provided. A further review of the electronic medical record did not reveal evidence of the required written notification of the room	F 559	any resident being moved will receive written notice including the reason for the change, before any room change. CRITERIA 2 All residents have the potential to be affected by this deficient practice. The Administrator met with 10 [redacted] and [redacted] residents. The Administrator educated and reminded the 10 [redacted] and [redacted] residents of their right to receive written notice before they move to another room. The residents understood. CRITERIA 3 The [redacted] Social Workers, and Nurse Supervisors completed the in-service "Room Change: In House." Their responsibilities are not limited to ensuring the residents have the right to receive written notice, including the reason for the change, before the resident's room in the facility is changed. CRITERIA 4 The Director of Social Services will audit room changes weekly for 6 months. These audits will be reviewed by the Administrator. For 2 quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team.	

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	315358	A. BUILDING _____ B. WING _____	C 08/02/2024

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F 559	Continued From page 2	F 559		

change.

2). On 08/02/24 at 11:33 A.M., the surveyor observed Resident #2 seated at the bedside in a wheelchair, watching television. The surveyor asked how long the resident had been in this room and the resident stated, "Sometime in [redacted] maybe [redacted]." The resident stated that the [redacted] informed his/her that the resident was "[redacted] and needed to be moved. The resident further stated that he/she had not received anything in writing prior to the move.

Review of Resident #2's Admission Record (AR) revealed that the resident was re-admitted to the facility with diagnoses that included but were not limited to: [redacted], [redacted], and [redacted].

Review of Resident #2's quarterly Minimum Data Set (MDS), dated [redacted] reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] out of 15, which indicated that the resident was [redacted].

Review of Resident #2's progress notes (PN) revealed a social worker note, dated [redacted] at 11:30 A.M., that indicated that the resident was transferred to another room and that written notification was not provided. A further review of the electronic medical record did not reveal evidence of the required written notification of the room change.

During an interview with the surveyor on 08/02/24 at 12:42 P.M., the [redacted] stated that she informed Resident #2 of the room change and that a notification was provided in writing to all residents. In a later

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	315358	A. BUILDING _____ B. WING _____	C 08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 559	Continued From page 3 interview, at 2:10 P.M., in the presence of the surveyor, the U.S. FOIA reviewed a facility form titled, "SUBJECT: Room Change, In-house." The U.S. FOIA stated that residents received the form which informed them of the room changes; no form was provided to the surveyor for Resident #1 nor Resident #2. During an interview with the surveyor on 08/02/24 at 1:30 P.M., the U.S. FOIA (b) (6) stated that she informed Resident #1 of the room change on the day of the move. She further stated that she had not provided the resident with a written notification. NJAC 8:39-4.1(a)	F 559		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060101	A. BUILDING: _____ B. WING _____	C 08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CEN	235 DOLPHIN AVE NORTHFIELD, NJ 08225

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 2 of 14 day shifts. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	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. Facility will follow the staffing plan by utilizing overtime, mandatory overtime, and agency staff to meet minimum staffing	8/30/24

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

Electronically Signed | 08/24/24

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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 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. -07/27/24 had 10 CNAs for 104 residents on the day shift, required at least 13 CNAs.	S 560	requirements. 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 required for each shift. The review of state minimum staffing level will be discussed in the daily management meeting. For 2 quarters, the results will be reported and reviewed in the quarterly QAPI (Quality Assurance Performance Improvement) meeting for continued compliance and or any recommendations by the QAPI team.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315358		9/27/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	235 DOLPHIN AVE NORTHFIELD, NJ 08225

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 F0559 Reg. # 483.10(e)(4)-(6) LSC	Correction Completed 08/30/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/2/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060101	A. Building B. Wing	9/27/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOWVIEW NURSING AND REHABILITATION CENTER	235 DOLPHIN AVE NORTHFIELD, NJ 08225

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/30/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/2/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO