STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315512	A. BUILDING ______ B. WING ______	01/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	**308 WILLOW AVENUE HOBOKEN, NJ 07030**

(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 STANDARD SURVEY: CENSUS: 4 SAMPLE: 4 The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. In addition, a COVID-19 Focused Infection Control Survey was conducted.	F 000		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		1/25/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/23/2023

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 812	Continued From page 1 Based on observations, interviews, and facility policy review, it was determined that the facility failed to ensure resident food items were labeled and dated and failed to discard all food items that had passed their expiration date. These failures had the potential to affect all 4 residents who resided in the facility. Findings included: Review of the facility's undated policy titled, "Food Safety Management System Guidelines," specified, "Food labeling is essential to identify food accurately, and ensure it is stored correctly. It is a [company name] requirement to discard all foods that have passed their "use by" or "best before" date. Food items that are decanted from their original packaging must be labeled." The policy further specified, "For pre-prepared/manufactured products, the label must reflect the products name, the opening date, and the use by date." Review of the facility's policy titled, "Food Storage," revised 09/2021, specified, "Purpose: To prevent all contamination by and transmission of disease-carrying microorganisms." The policy further specified, "Procedure - Follow the guidelines below to further ensure safe and accurate storage procedures: 3. Rotate stock so that older items are used first. Date products to ensure the use of "First-In, First-Out" procedures." 1. On 01/03/2023 at 11:39 AM, an observation of the dry storage area revealed 10 8-ounce Glucerna Nutrition Shakes with an expiration date of 01/01/2023.	F 812	1. Expired supplements: a. All expired products were discarded. b. All enteral nutrition products will be checked daily for expiration date ensuring removal by the day prior to date of expiration on product. c. All residents may be affected by receiving poor quality enteral nutrition products. d. Food and nutrition employees will ensure that there are no expired enteral nutrition products in the dry storage area. All food and nutrition service employees responsible for handling enteral nutrition products will receive in-service training to ensure expired products are discarded appropriately. e. Food safety audits, including monitoring of expired enteral products, will be conducted daily by food and nutrition manager. Results of the audits will be reported to the TCU Quality Assurance Performance Improvement Committee every quarter until 100% compliance has been achieved and maintained. f. Corrective action will be completed 1-25-2023. 2. Unlabeled food products: a. All existing opened food items were appropriately labeled and dated. b. All food products that have been opened will be labeled and dated consistently with product name and expiration date. c. All residents will be affected by poor food quality. d. Food and nutrition employees will ensure that there are no unlabeled	

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F 812	Continued From page 2 During an interview on 01/04/2023 at 12:02 PM, the Clinical Nutritional Manager stated expired foods should be discarded by their use-by date and she expected foods to be discarded by their use-by date. During an interview on 01/04/2023 at 12:03 PM, the Project Manager (PM) stated expired foods should be discarded by their use-by date. According to the PM, she expected expired foods to be discarded by their expiration date. During an interview on 01/04/2023 at 3:01 PM, with the Interim Director of Nursing (DON) and the Administrator, both stated that expired foods should be discarded by their expiration date. Per the Interim DON and Administrator, they expected expired foods to be discarded by their expiration date. The Administrator stated she completed occasional spot checks in the kitchen, but the last check was in September of 2022. According to the Administrator, the Director of Food Services was given the Centers for Medicare and Medicaid (CMS) Critical Element Pathway to follow. During an interview on 01/04/2023 at 4:20 PM, the Director of Food Services (DFS) stated all food managers should make rounds to check for expired food. Per the DFS, she expected daily rounding by the food managers to monitor use-by dates on food. The DFS indicated staff were aware that food items must be discarded by their use-by dates. 2. On 01/03/2023 at 11:43 AM, an observation of the walk-in cooler revealed a bag of green beans out of the original container with no label or date, a 41-ounce opened bag of flour tortillas with no opened date, an opened 2 pound bag of mild	F 812	products in the storage area. All food and nutrition service employees responsible for handling food products will receive in-service training to ensure food products are labeled appropriately. e. Food safety audits, including monitoring of unlabeled food products, will be conducted daily by food and nutrition manager. Results of the audits will be reported to the TCU Quality Assurance Performance Improvement Committee every quarter until 100% compliance has been achieved and maintained. f. Corrective action will be completed 1-25-2023.	

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F 812	Continued From page 3 cheddar cheese with no opened date, and an opened 32-ounce bag of crumbled goat cheese with no date. On 01/03/2023 at 11:52 AM, observations of the walk-in freezer revealed six bags of hash browns out of the original containers, with no date or label, and a round cake out of the original packaging, with no label or date. During an interview on 01/04/2023 at 12:02 PM, the Clinical Nutritional Manager stated food items out of their original packaging or food items that have been opened should be dated and labeled. She stated she expected food items to be dated and labeled when out of the original packaging or after the food item had been opened. During an interview on 01/04/2023 at 12:03 PM, the Project Manager (PM) stated food items out of their original packaging or opened should be dated and labeled. According to the PM, she expected food items to be dated and labeled when out of the original packaging or after the food item had been opened. Per the PM, many of the kitchen staff were new, and the facility was projected to implement a new labeling system in the future. During an interview on 01/04/2023 at 3:01 PM, with the Interim Director of Nursing (DON) and Administrator, both stated food items out of their original packaging or after they were opened should be dated and labeled. Per the Interim DON and Administrator, they expected food items to be dated and labeled after being opened or out of their original container. The Administrator stated she completed occasional spot checks in the kitchen, but the last check was in September	F 812		

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F 812	Continued From page 4 of 2022. According to the Administrator, the Director of Food Services was given the Centers for Medicare and Medicaid (CMS) Critical Element Pathway to follow. During an interview on 01/04/2023 at 4:20 PM, the Director of Food Services (DFS) stated it was a team effort to monitor for proper labeling and dating of food items. The DFS stated all food managers should make rounds to check for proper labeling and dating of food items. Per the DFS, she expected daily rounding by the food managers to observe for proper dating and labeling. The DFS indicated staff were aware that food items must be labeled when out of the original packaging or after opened. NJAC 8:39-17.2(g)	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		1/25/23

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F 880	Continued From page 5 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 6 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of the facility's guidelines, it was determined that the facility failed to ensure Ex Order 26. 4B1 was properly dated and properly stored when not in use and there was a storage containment bag to place the Ex Order 26. 4B1 and Ex Order 26. 4B1 when not in use for 2 (Resident #7 and Resident #8) of 2 residents reviewed for Ex Order 26. 4B1. Findings included: A review of the facility's undated guidelines titled, "TCU Unit Guidelines Resident Room Checklist Each Shift," indicated, 'Ex Order 26. 4B1 label and date within last 72 hours and placed in a plastic bag when not in use." 1. A review of the resident demographic sheet revealed the facility admitted Resident #8 with diagnoses of Ex Order 26. 4B1 . A review of Resident #8's "TCU Baseline Plan of Care," initiated Ex Order 26. 4B1, revealed Resident #8 was to receive services and treatment for Ex Order 26. 4B1 and Ex Order 26. 4B1. A review of Resident #8's "Current Orders" revealed an order, dated Ex Order 26. 4B1, for Ex Order 26. 4B1	F 880	1. All new Ex Order 26. 4B1 must be labeled and dated during first use of the equipment and properly stored in a plastic bag when not in use. 2. All residents may be affected by not properly storing Ex Order 26. 4B1 when not in use. 3. In-service training for all TCU staff will be conducted to remind the staff of the safe storage of Ex Order 26. 4B1 when not being used by the residents for infection control and prevention compliance. All nursing staff in each shift will check to ensure all Ex Order 26. 4B1 are appropriately labeled and dated and properly stored in a plastic bag during bedside rounding. 4. The infection preventionist will conduct weekly surveillance to ensure that all Ex Order 26. 4B1 being used by the residents are labeled and dated, and properly stored in a plastic bag when not being used. Results of the weekly surveillance will be reported to the Quality Assurance Performance Improvement Committee until 100% compliance have been achieved and maintained. 5. Completion date 1-25-2023.	

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F 880	Continued From page 7	F 880		

by way of Ex Order 26. 4B1 at Ex Order 26. 4B1 as needed.

On 01/03/2023 at 11:13 AM, Resident #8 was observed sitting in a chair in the resident's room with Ex Order 26. 4B1 lying on the bed and an Ex Order 26. 4B1 hanging off the right side of the bed. The Ex Order 26. 4B1 was not dated and had no storage containment bag present in the room. Resident #8 stated they did not place the Ex Order 26. 4B1 on the side of bed and indicated staff had taken it off and placed it on the side of the bed.

On 01/03/2023 at 11:15 AM, Registered Nurse (RN) #1 was called to Resident #8's room by the surveyor, where she acknowledged that Resident #8's Ex Order 26. 4B1 was stored off the side of the bed, the Ex Order 26. 4B1 was not dated, and the Ex Order 26. 4B1 did not have a storage bag present in the room for its storage when not in use. RN #1 stated the Ex Order 26. 4B1 should be dated and have a containment bag to place them in when not in use. Per RN #1, the nurses were responsible for dating the tubing when new tubing was changed out and for placing a new storage bag in the room. RN #1 indicated the Ex Order 26. 4B1 should not be stored hanging off the side of the resident's bed. According to RN #1, she did not know why the Ex Order 26. 4B1 was stored on the side of the bed.

During a follow up interview on 01/03/2023 at 3:39 PM, RN #1 stated she changed out Resident #8's Ex Order 26. 4B1 that was not dated with new tubing with the current date and placed a containment bag for the storage of the Ex Order 26. 4B1. RN #1 indicated the Ex Order 26. 4B1 should be changed every 72 hours and dated after it was changed.

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F 880	Continued From page 8 On 01/04/2023 at 7:33 AM, Resident #8 was observed in bed in their room with a Ex Order 26. 4B1 on their face. Resident #8's Ex Order 26. 4B1 was dated and there was a storage containment bag present. On 01/04/2023 at 7:34 AM, RN #2 stated Ex Order 26. 4B1 and the Ex Order 26. 4B1 should be changed and dated every seven days on Mondays or when dirty. RN #2 stated the Ex Order 26. 4B1 should not be stored hanging off the resident's bed and should be stored in a bag when not in use. Per RN #2, the potential negative outcome of not storing the Ex Order 26. 4B1 properly was Ex Order 26. 4B1 . On 01/04/2023 at 7:42 AM, the Interim Director of Nursing (DON) stated Ex Order 26. 4B1 should be dated when changed every 72 hours or as needed. He stated the Ex Order 26. 4B1 should be stored in a bag when not in use. Per the Interim DON, the Ex Order 26. 4B1 should not be stored off the side of a resident's bed. According to the Interim DON, the potential negative outcome of not storing the Ex Order 26. 4B1 properly were potential Ex Order 26. 4B1 . The Interim DON stated the facility did not have a specific policy on dating the Ex Order 26. 4B1, or on the proper storage and containment of the Ex Order 26. 4B1 when not in use. On 01/04/2023 at 7:47 AM, the Administrator stated Ex Order 26. 4B1 should be dated and changed every 72 hours. Per the Administrator, the Ex Order 26. 4B1 should be contained in a storage bag when not in use and not hanging off the resident's bed. According to the Administrator, a potential negative outcome of	F 880		

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F 880	Continued From page 9 not properly storing the Ex Order 26. 4B1, dating the Ex Order 26. 4B1, and having a storage bag to place the Ex Order 26. 4B1 when not in use was an infection control issue. The Administrator stated she expected the Ex Order 26. 4B1 to be stored properly when not in use, dated when changed, and to have a storage bag for when the supplies were not in use. 2. A review of the resident demographic sheet indicated the facility admitted Resident #7 with diagnoses that included Ex Order 26. 4B1 . A review of Resident #7's "TCU Baseline Plan of Care," initiated Ex Order 26. 4B1, revealed the resident received Ex Order 26. 4B1. A review of Resident #7's "Current Orders," revealed an order, dated Ex Order 26. 4B1, for Ex Order 26. 4B1 by way of Ex Order 26. 4B1 at Ex Order 26. 4B1. During an observation on 01/03/2023 at 9:37 AM, Resident #7 was not present in their room; however, the resident's Ex Order 26. 4B1 was in their room with the tubing connected, and the Ex Order 26. 4B1 was lying on top of an Ex Order 26. 4B1 pad on the resident's bed. The surveyor observed that the Ex Order 26. 4B1 was not dated. On 01/04/2023 at 9:02 AM, Resident #7 was observed sitting in their room in a wheelchair with a Ex Order 26. 4B1 on their face. Resident #7's Ex Order 26. 4B1 was dated Ex Order 26. 4B1; however, there was no storage bag in the resident's room to place the Ex Order 26. 4B1 when not in use. During an interview on 01/04/2023 at 12:45 AM, the Interim Director of Nursing (DON) stated Ex Order 26. 4B1 should be changed every 72 hours	F 880		

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F 880	Continued From page 10 and stored in a plastic bag when not in use. According to the Interim DON, the Ex Order 26. 4B1 [redacted] and nursing staff were responsible for changing the Ex Order 26. 4B1. NJAC 8:39-19.4(a)1-6	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315512	A. Building B. Wing	3/8/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	308 WILLOW AVENUE HOBOKEN, NJ 07030

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 F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 01/25/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 01/25/2023	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	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 1/5/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	315512	A. BUILDING **01** B. WING ______________	**01/05/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOBOKEN UNIVERSITY MEDICAL CENTER TCU	**308 WILLOW AVENUE** **HOBOKEN, NJ 07030**

(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
E 000	Initial Comments This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 01/05/2023 and Hoboken University Medical Center TCU was found to be in compliance with the 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 Occupancies.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/17/2023

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.