STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315525	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD , NORTH BERGEN, New Jersey, 07047

(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
F0000	INITIAL COMMENTS Complaint NJ#175713 Survey Date: 8/21/2025 Census: 55 Sample: 14 sample + 3 closed records =17 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.	F0000		09/05/2025
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584	Element I The facility immediately corrected identified deficiencies. Disinfecting sprays were removed from resident rooms, vents were cleaned in all shower rooms, paper towels were restocked, and maintenance repaired the dresser, closet, and ceiling in the affected rooms. Element II The residents that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III Daily rounds are conducted by the Housekeeping Director or designee. - Maintenance logs are now maintained and reviewed weekly. - Staff re-educated on hazardous chemical storage and	09/05/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315525	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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F0584 SS = D	Continued from page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of other facility documentation, the facility failed to ensure the facility was maintained in a safe, clean, and homelike environment. This deficient practice was identified for 3 of 4 Resident Rooms (Rooms [redacted] and [redacted] and 1 of 2 shower rooms. This deficient practice was evidenced by the following: 1.On 8/18/25 at 10:38 AM, Surveyor #1 (S#1) with the [redacted]) toured the West unit and did random tour of the unit rooms. Both S#1 and the [redacted] went inside Resident Room #[redacted] (RR#[redacted] Upon entry, on the right side the closet was unable to fully closed, and the [redacted] moved the clothes inside the closet and stated that there were too much residents' clothes inside the closet that was why it was not closing well. Both S#1 and the [redacted] observed the toilet room with no paper towel. The 1st bed's dresser second to the last drawer was uneven and the [redacted] opened the drawer and stated that there were overflowing clothes that was why it was uneven and unable to close the drawer. On that same date and time, both S#1 and the [redacted] went inside the West unit shower room and observed the following:	F0584	Continued from page 1 room safety standards. - Nursing staff in-service monitor rooms and report environmental concerns. Element IV Five rooms at random will be audited to ensure drawers are neat and able to close, closet doors close properly, no hazardous items are at bedside, ceiling tiles are not stained or broken, the audit will be as follows: weekly x 4 weeks, then bi-weekly x 2 months, then monthly x3 months. Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meetings by the Housekeeping Director. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting.	

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F0584 SS = D	Continued from page 2 -The 1st cubicle upon entry from the door, the two vents on the ceiling with accumulation of grayish substances which the U.S. F confirmed was accumulation of dust. -The next cubicle with accumulation of dust in the vent. The U.S. F confirmed that it was the housekeeper's responsibility to ensure that the vents were cleaned. Afterward, both S#1 and U.S. F went inside RR# [redacted] and observed behind the window curtains there were two containers of disinfecting sprays with resident name on it. On 8/18/25 at 10:50 AM, the U.S. F called the assigned nurse, and it was the U.S. FOIA (b) (6) [redacted] who came inside RR# [redacted] The U.S. FOIA (b) and stated that there should be no disinfecting sprays inside the room. On 8/18/25 at 10:55 AM, both S#1 and U.S. F toured East unit and went inside the shower room and observed the vent on the ceiling with accumulation of grayish substances which the U.S. F confirmed accumulation of dust and should have been cleaned. The U.S. F further stated that it was the housekeeper's responsibility to clean the vents in the shower rooms every day. At that same time, S#1 asked the U.S. F if the vents looked like it was cleaned every day and he responded that "somewhat not." He also stated that he started as U.S. F NJ Ex Order 26.4(b) and "to be honest" there was no accountability log for cleaning the vents. On 8/19/25 at 2:15 PM, the survey team met with the U.S. FOIA (b) (6) [redacted]) and the U.S. FOIA (b) (6) [redacted]), and S#1 notified them of the above findings and concerns. S#1 asked the U.S. FOIA (and U.S. FOIA who was responsible for RR# NJ E 's closet and dresser, and the U.S. FOIA stated the resident's clothes the U.S. FOIA would be responsible to ensure they were folded. She further stated that it would be the responsibility of the Maintenance to fix dresser and closet. The U.S. FOIA also stated that the disinfecting spray could cause harm to any resident and should be stored properly. S#1 asked for a copy of the facility's policy with regard to homelike environment. On 8/21/25 at 11:55 AM, the survey team met with the U.S. FOIA (b) (6) [redacted]), U.S. FOIA (b) and the U.S. FOIA (S#2 asked about the facility's homelike environment policy that was asked by S#1, and the U.S. FOIA (stated that the facility had no policy.	F0584		

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F0584 SS = D	Continued from page 3 2. On 8/14/25 at 1:02 PM, during the initial tour of the facility, Surveyor #3 (S#3) observed, in RR#[NJ E]'s room, the ceiling directly across from the resident's bed, over the resident's TV (television) and dresser, an area that had some brownish discoloration and a rectangular shaped area that was not the same level or consistency as the rest of the ceiling and appeared that it may be missing a thin section of ceiling material. On 8/18/25 at 12:02 PM, S#3 observed RR#[NJ E]'s room again, with the same area of ceiling as before with no changes. On 8/18/25 at 12:16 PM, S#3 in the presence of the [U.S. FOIA (] observed the ceiling area in RR#[NJ Exe] room. The [U.S. FOIA (] stated "it looks like something came down". S#3 notified the [U.S. FOIA (] that they first observed it on 8/14/25. The [U.S. FOIA (] stated "maintenance may not have gotten to it yet". S#3 asked the [U.S. FOIA (] to provide a log or other document stating that it was in process of being repaired and the facility was aware. At that same time, S#3 attempted to locate any maintenance or repair logbook in the nursing station where the resident's room was located. S#3 could not locate any book or documents. On 8/18/25 at 12:23 PM, S#3 asked the [U.S. FOIA (b) (6)] on the West unit [U.S. FOIA (b) (6)]) how the staff reports any concerns or repair needs to maintenance or other appropriate department. The [U.S. FOIA (b) (] stated that there was an electronic reporting system (ERS) with an app on her phone. The system sends it to the appropriate department, it was time stamped and dated, there was no paper trail that they were aware of. On 8/18/25 at 12:33 PM, S#3 asked the [U.S. FOI] assigned to East wing [U.S. FOIA (b) (]) how maintenance requests were handled. The [U.S. FOIA (b] stated that they call the front desk to get maintenance person to come, they did not use any ERS. On 8/18/25 at 12:40 PM, S#3 asked the [U.S. FOIA (b) (6)] on how they were informed of any repair concerns. The [U.S. FOIA] stated that they use the ERS, get a phone call or will get paged. At the same date and time, S#3 observed two maintenance workers come out of [NJ Exec Of]'s room. The [U.S. FOIA] stated that the workers had a printout of maintenance requests but could not show the surveyor any repair order for [NJ Exec Of]'s room. The [U.S. FOIA] also stated that they will fix the ceiling right away. On 8/19/25 at 2:15 PM the survey team met with the [U.S. FOIA (]	F0584		

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F0584 SS = D	Continued from page 4 and U.S. FOIA for concerns. S#3 informed the U.S. FOIA (and U.S. FOIA of the concern with homelike environment for RR#NJ E's room. The U.S. FOIA (stated that the ceiling was being repaired. S#3 asked the U.S. FOIA (for any policies for Maintenance or Homelike Environment. On 8/20/25 at 1:06 PM, the survey team met with the U.S. FOIA (and U.S. FOIA for responses to concerns. The U.S. FOIA (stated that the ceiling was fixed right away after surveyor's inquiry. The U.S. FOIA (stated that they had no separate policy for Maintenance or Homelike Environment and that the facility just follows the regulations and use the ERS app on staff phones or computer to address issues. The facility did not provide any further pertinent information. NJAC 8:39-31.2(e); 31.4(a)(b)(f)	F0584		
F0636 SS = D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems.	F0636	Element I Residents #57 and #62 had their Minimum Data Set (MDS) assessments reviewed and completed. No other residents were found to be overdue. Element II The residents that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III In-service education was provided to the social worker, dietician, U.S. FOIA (b) (6) , U.S. FOIA (b) (U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) on 8/25/2025, on completing sections of the MDS timely for MDS assessments to be completed and submitted timely by the Director of Nursing. The Regional MDS Coordinator in-serviced the U.S. FOIA (on the facility MDS policy and procedures on Transmitting residents' assessments which follows the Resident Assessment Instrument Manual to maintain compliance with CMS and the state regulations. Element IV	09/05/2025

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F0636 SS = D	Continued from page 5 (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on the interview and record review, it was determined that the facility failed to complete the comprehensive Minimum Data Set (MDS) assessment in accordance with the Resident Assessment Instrument (RAI) manual and facility policy for 2 of 17 (Residents #57 and #62) residents reviewed for comprehensive	F0636	Continued from page 5 Five assessments will be audited at random. The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting.	

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F0636 SS = D	Continued from page 6 resident assessments. This deficient practice was evidenced by the following: Reference: Centers For Medicare and Medicaid Services (CMS), RAI manual, Version 3.0, last revised in October 2024, indicated in Chapter 2, pages 2-8 revealed:...Admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 AM and ends at 11:59 PM regardless of whether admission occurs at 12:00 AM or 11:59 PM, this date is considered the 1st day of admission... Under Chapter 2, Section 2.6-Required OBRA [Omnibus Budget Reconciliation Act] Assessments for the MDS revealed:…MDS Completion Date (Item Z0500B) No Later Than… 14th calendar day of the resident's admission (admission date + 13 calendar days) … The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1if…this is the resident's first time in this facility, OR…the resident has been admitted to this facility and was discharged return not anticipated, OR…the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.… Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the admission comprehensive assessment at any time prior to the end of day 14. On 8/20/25 at 9:56 AM, the surveyor reviewed the MDS assessments of the following residents which revealed: A review of Resident #62's comprehensive MDS with an Assessment Reference Date (ARD) of NJ Ex Order 26.4 revealed that the MDS was dated and signed as complete on NJ Ex Order 26. The resident's date of admission was NJ Ex Order 26.4 The MDS assessment was completed more than 14 days after the admission date. A review of Resident #57's comprehensive MDS with an ARD of NJ Ex Order 26 revealed that the MDS was dated and signed as complete on NJ Ex Order 26 The resident's date of admission was NJ Ex Order 26. The MDS was completed more than	F0636		

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F0636 SS = D	Continued from page 7 14 days after the admission date. On 8/20/25 at 10:13 AM, the surveyor interviewed the U.S. FOIA (b) (6)) over the phone, who stated an comprehensive MDS assessment should be completed within 14 days. The surveyor asked the U.S. FOIA (b) (6) if the facility had an MDS policy and if she followed the RAI manual. The U.S. FOIA (b) (6) stated would have to get back to the surveyor. The surveyor notified the U.S. FOIA (b) (6) about the concern for the late completion for Resident #57 and Resident #62's MDS assessments. The U.S. FOIA (b) (6) stated she would review and provide a response to the surveyor. On 8/20/25 at 12:01 PM, the U.S. FOIA (b) (6) spoke with the surveyor over the phone. The U.S. FOIA (b) (6) acknowledged the identified MDS assessments were completed late. The U.S. FOIA (b) (6) confirmed the timeframe to complete the Admission MDS assessment was 14 days from the admission date, which was considered day 1. The U.S. FOIA (b) (6) stated the facility had an MDS policy and they followed the RAI manual. On 8/20/25 at 1:06 PM, the surveyor notified the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) regarding the concern of late MDS completion for Residents' # 57 and #62. On 8/21/25 at 11:55 AM, the U.S. FOIA (b) the U.S. FOIA and the U.S. FOIA (b) (6), met with the survey team. The U.S. FOIA stated in-service education was provided to the social worker and other departments about completing sections of the MDS timely for MDS assessments to be completed and submitted timely. The U.S. FOIA added the facility would initiate a Quality Assurance Performance Improvement (QAPI) project to address the identified concern. A review of the facility's "Policy-MDS 3.0 Completion" with a reviewed/revised date of 10/1/2024, under Policy Explanation and Compliance Guidelines revealed:..Admission Assessment- completed within 14 days of admission counting the day of admission as day #1. Required when: i. The resident has no prior admission. Or, ii. Prior admission was less than 14 days AND no admission assessment was completed during the prior admission. Or, iii. Prior admission ended with a Discharge Return not Anticipated; or prior admission ended with a Discharge Return Anticipated AND re-entry occurred > 30 days after the discharge date…	F0636		

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F0636 SS = D	Continued from page 8 NJAC 8:39-11.1, 11.2(e)(h)	F0636		
F0640 SS = D	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. §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	F0640	Element I Residents #4, #5, and #19 had their Minimum Data Set (MDS) assessments reviewed and completed. No other residents were found to be overdue. Element II Residents with late assessments that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III U.S. FOIA (b) (6) was educated on the criteria of 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: admission assessment, annual assessment, significant change in status assessment, significant correction of prior full assessment, significant correction of prior quarterly assessments, quarterly review, a subset of items upon a resident's transfer, reentry, discharge and death. Element IV Five assessments will be audited at random The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meeting. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting.	09/05/2025

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F0640 SS = D	Continued from page 9 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 interview and record review, it was determined that the facility failed to transmit a Minimum Data Set (MDS) assessment, an assessment tool used to facilitate the management of care, within the appropriate timeframe and in accordance with federal guidelines for 3 of 17 residents (Residents #4, #5, and #19), reviewed for resident assessments. This deficient practice was evidenced by the following: Reference: Centers For Medicare and Medicaid Services (CMS), RAI manual, Version 3.0, last revised in October 2024, indicated in Chapter 2, Section 2.6-Required OBRA [Omnibus Budget Reconciliation Act] Assessments for the MDS revealed:...The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1if…this is the resident's first time in this facility, OR…the resident has been admitted to this facility and was discharged return not anticipated, OR…the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.… Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the admission comprehensive assessment at any time prior to the end of day 14...	F0640		

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F0640 SS = D	Continued from page 10 Under Chapter 5, Section 5.2 Timeliness Criteria revealed:…Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days) … On 8/20/25 at 9:03 AM, the surveyor reviewed the MDS assessments of the following residents: A review of system selected Resident #19's comprehensive MDS with an Assessment Reference Date (ARD) of NJ Ex Order 28, revealed that the MDS was transmitted on NJ Ex Order 28. The MDS assessment was transmitted more than 14 days after the MDS assessment's completion. A review of Resident #4's comprehensive MDS with an ARD of NJ Ex Order 28, revealed that the MDS was transmitted on NJ Ex Order 28. The MDS assessment was transmitted more than 14 days after the MDS assessment's completion. A review of Resident #5's comprehensive MDS with an ARD of NJ Ex Order, revealed that the MDS was transmitted on NJ Ex Order 28. The MDS assessment was transmitted more than 14 days after the MDS assessment's completion. On 8/20/25 at 10:13 AM, the surveyor interviewed the U.S. FOIA (b) (6)) over the phone, who stated a comprehensive MDS assessment should be completed within 14 days, and she would have to get back to the surveyor on the timeframe for the MDS to be transmitted to CMS. The surveyor asked the U.S. FOIA (b) (6) if the facility had an MDS policy and if she followed the RAI manual. The U.S. FOIA (b) (6) stated she would have to get back to the surveyor. The surveyor informed the US FOIA (b)(6) about concern for the late submission of Resident #4, #5, and #19's MDS assessments. The U.S. FOIA (b) (6) stated she would review and provide a response to the surveyor. On 8/20/25 at 12:01 PM, the U.S. FOIA (b) (6) spoke with the surveyor over the phone. The U.S. FOIA (b) (6) acknowledged the identified MDS assessments were late. The U.S. FOIA (b) (6) stated the timeframe for the submission of the MDS assessment was from care plan completion plus 14 days. The U.S. FOIA (b) (6) stated the facility had an MDS policy and they followed the RAI manual. On 8/20/25 at 1:06 PM, the surveyor informed the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) regarding the concern of late MDS submission for Residents' # 4, #5, and #19. On 8/21/25 at 11:55 AM, the U.S. FOIA (b) the U.S. FOIA and the U.S. FOIA (b) (6), met with the survey team. The U.S. FOIA stated	F0640		

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F0640 SS = D	Continued from page 11 in-service education was provided to the social worker and other departments about completing sections of the MDS timely for MDS assessments to be completed and submitted timely. The [U.S. FOR] added the facility would initiate a Quality Assurance Performance Improvement (QAPI) project to address the identified concern. A review of the facility's "Policy-MDS 3.0 Completion" with a reviewed/revised date of 10/1/2024, under Policy Explanation and Compliance Guidelines revealed:..Admission Assessment- completed within 14 days of admission counting the day of admission as day #1. Required when: i. The resident has no prior admission. Or, ii. Prior admission was less than 14 days AND no admission assessment was completed during the prior admission. Or, iii. Prior admission ended with a Discharge Return not Anticipated; or prior admission ended with a Discharge Return Anticipated AND re-entry occurred > 30 days after the discharge date… Facility Compliance with Transmission of Assessments a. All applicable completion date time frames must be met in order for the transmission time frames listed below to be applicable and accurate. Any non-adherence to completion deadlines debases the timeline transmission. Both completion and transmission deadlines must be met to be in compliance… NJAC 8:39-11.1, 11.2(e)(h)	F0640		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to; a.) ensure the care plan was updated and monitored the [NJ Ex Order 26.4] episodes for 1 of 5 residents (Resident #5), b.) ensure rationale for the discontinuation of medication was	F0658	Element I Residents #5, #31, #24, and #62 were reassessed with [NJ E] [redacted] noted. All current wound care, behavior monitoring and pain management charts were reviewed to identify additional omissions, and no new omissions were found. CP updated to reflect proper dx of psychotropic medication for resident #5. Element II The residents that reside in the facility with orders	09/05/2025

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F0658 SS = D	Continued from page 12 documented for 1 of 5 residents (Resident #62), reviewed for unnecessary medications, and c.) follow a physician's order for 3 of 17 residents (Residents #5, #24, and #31) reviewed, in accordance with standards of clinical practice. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case-finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.On 8/14/25 at 10:17 AM, Surveyor #1 (S#1) observed Resident #5 asleep in the resident's bed. On 8/14/25 at 1:01 PM, S#1 reviewed Resident #5's medical record. A review of Resident #5's Admission Record face sheet (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) [redacted]), and NJ Ex Order 26.4(b)(1) [redacted]).	F0658	Continued from page 12 for psychotropic medications, wound treatments and pain assessments have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III 8/25/2025 Mandatory training for all clinical staff on charting and documentation protocols for pain, wound care, and behavior monitoring done by the Director of Nursing. All licensed nursing staff received mandatory wound care training on 8/25/2025, including protocols for early identification and escalation by the Director of Nursing. License staff were educated on the facilities Behavior Assessment and Monitoring Policy which is used to monitor and document the occurrence of any problematic behaviors, interventions implemented, and the resident response to interventions when these behaviors occur by the Director of Nursing. The Interdisciplinary Care Plan team and the Unit Manager received education on developing comprehensive, person-centered care plans. Following each assessment, the IDCP team will review and revise the care plan, ensuring that new and modified interventions are incorporated to accurately reflect the resident's current needs by the Director of Nursing. The Director of Nursing or designee will conduct 5 random chart audits of residents with wound care documentation, pain assessments and behavior monitoring. The audit will be conducted weekly x4 weeks, bi-weekly for 2 months and then monthly for 3 months. Element IV The completion of audits will be monitored by the Administrator, Director of Nursing or designee weekly for 4 weeks, every two weeks for 2 months and monthly for 3 months. Results of the audit will be presented to the Quality Assessment and Assurance Committee during monthly Quality Assurance and Performance Improvement	

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F0658 SS = D	Continued from page 13 A review of Resident #5's Admission Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of NJ Ex Order, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of N out of 15, which indicated that Resident #5's NJ Exec Order 26 was NJ Ex Order 26.4(b)(1). Further review reflected that the resident received NJ Ex Order 26.4(b)(1)). A review of Resident #5's electronic Medication Administration Record/electronic Treatment Administration Record (eMAR/eTAR) included the following order: NJ Ex Order 26.4(b)(1) give 1 tab by mouth two times a day (2x/day) for NJ Ex Order 26.4(b)(1) A review of Resident #5's NJ Ex Order 26.4(b)(Consult dated NJ Ex Order, reflected under recommendations that the NJ Ex Order 26.4(b)(1) was ordered for NJ Ex Order 26.4(b)(1). A review of the U.S. FOIA (b) (6) Monthly Report for Resident #5 included the following suggestion: Please clarify and update the diagnosis for NJ Ex Order 26.4(b . Make sure there is sufficient documentation to support diagnosis. Please review NJ Ex Or . A review of Resident #5's NJ Ex Order 26.4(b)(1) eMAR/eTAR included the following order that was changed on NJ Ex Order 2 NJ Ex Order 26.4(b)(1) , give 1 tab by mouth 2x/day for NJ Ex Order 26.4(b)(1)). A review of Resident #5's comprehensive care plan (CP) included the following focus area: Resident #5 uses NJ Ex Order 26.4(b)(1) medications (meds) r/t (related to) NJ Ex Order 26.4(management, NJ Ex Order 26.4(b)(1) with an initiated date of NJ Ex Order 2 The resident's CP was not updated to reflect the corrected diagnosis of NJ Ex Order 26.4(b)(1) for the NJ Ex Order 26.4(b)(1) medication (med) order that was updated on NJ Ex Order 2 Further review of Resident #5's NJ Ex Order 26.4(b)(1) eMAR/eTAR included the following orders related to NJ Ex Order 26.4	F0658	Continued from page 13 meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting. Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting.	

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F0658 SS = D	Continued from page 14 NJ Ex Order 26.4(b)(for the NJ Ex Order 26.4(b)(1) med: NJ Ex Order 26.4(b)(1) Monitoring every shift NJ Ex Order 26.4(b)(1)) EXHIBITED: NJ Ex Order 26.4(b)(1) [redacted]. The order had a section for the key NJ Ex Order 26.4 and nurses initial. The order did not have a section for how many episodes of the NJ Ex Order 26.4 the resident exhibited in a shift. NJ Ex Order 26.4(b)(1) Monitoring every shift INTERVENTION(S): NJ Ex Order 26.4(b)(1) [redacted]. The order had a section for the key intervention and nurses initial. A review of Resident #5's NJ Ex Order 26.4(b)(1) Initial Evaluation/Monthly Review with an effective date of NJ Ex Order 26, did not indicate the amount of NJ Ex Orde [redacted] exhibited for the month. On 8/19/25 at 10:49 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding NJ Ex Order 26.4 [redacted] and care plans. LPN #1 stated that NJ Ex Order 26.4(b) were monitored each shift and would expect to see how many episodes. LPN #1 did not know who calculated the episodes for the monthly report. LPN #1 was not sure who updated the care plan. On 8/19/25 at 11:03 AM, S#1 interviewed the U.S. FOIA (b) (6) [redacted] regarding NJ Ex Order 26.4(b)(1) and care plans. The U.S. FOIA stated that there was an order for NJ Ex Order 26.4(b)(1) in the electronic medical record that was kind of general r/t NJ Ex Order 26.4(b)(1). She added that she would look at the eMAR/eTAR to see how many episodes, if any that the resident had for the NJ Ex Order 26.4(b)(1) monthly summary which was used related to NJ Ex Order 26.4(b)(1) [redacted]). S#1 then asked the U.S. FOIA who was responsible for CP updates and how often done. The U.S. FOIA stated that it was usually herself and the U.S. FOIA (b) (6) [redacted] The U.S. FOIA stated that updates were done as needed. S#1 showed the U.S. FOIA Resident #5's CP and NJ Ex Order 26.4(b)(1) order. S#1 asked if the CP should have been updated when the indicated diagnosis for the NJ Ex Order 26.4(b)(1) med was changed. The U.S. FOIA stated that the CP should have been updated. S#1 asked the U.S. FOIA if the NJ Ex Order 26.4(b)(1) order should have how many NJ Exec Order 26 of the NJ Exec Order 26 in the shift. The U.S. FOIA stated that the order was lacking the NJ Exec Order [redacted] part. A review of the undated facility's "Interdisciplinary	F0658		

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F0658 SS = D	Continued from page 15 Care Planning Policy and Procedures" included the following: Procedure 11. Since the CP is a dynamic document, in the interim between quarterly reviews, the IDC (interdisciplinary) team MUST revise problems, goals, and interventions in response to changes in the needs of resident. A review of the facility's "Psychoactive Medication Use and GDR Policy" dated 10/23, included the following: Policy: It is the policy of this facility to ensure all Residents receiving psychoactive meds are evaluated for a GDR in compliance with regulatory requirements. Policy Statement: To ensure that psychoactive meds are utilized appropriately in compliance with state and federal regulations and to comply with the guidelines related to unnecessary drug use. To comply with regulatory guidelines for the GDR of each psychoactive med class, (including antidepressants). The goal of GDR is to evaluate the need for the med and to determine if the resident is maintained on the lowest possible dose. To maintain resident free from unnecessary meds, as excessive doses, excessive duration, lack of adequate monitoring, lack of adequate indicator for use, or continued use in the presence of adverse consequences. To attempt non-drug interventions and document the outcome in the medical record prior to the use of psychoactive meds whenever clinically appropriate. A review of the facility's "Behavior Assessment and Monitoring Policy" dated 9/24, included the following: Monitoring 1. Exception charting will be used to document the occurrence of any problematic behaviors, interventions implemented, and the resident response to interventions when these behaviors occur. 2. Monthly, behavior monitoring summaries will be	F0658		

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F0658 SS = D	Continued from page 16 completed by nursing that summarizes the occurrence of target behaviors and the effectiveness of interventions. 3. For residents with ordered psychoactive meds, information from the monthly summaries along with psychiatric and/or medical re-evaluation will be used to determine if a GDR is feasible or contraindicated as determined by the psychiatrist… 2. A review of Resident #5's NJ Ex Order 26.4(b)(1) eTAR included the following: NJ Ex Order 26.4(b)(1) [redacted] one time a day for NJ Ex O for 7 Days. The NJ Ex Order 26 1100 administration was blank. Assess resident for the following symptoms: NJ Ex Orde [redacted] Document "YES" if symptoms are noted, notify MD (Medical Doctor) and follow up with a progress note (PN) every shift. The NJ Ex Order day shift, NJ Ex Order 2 day shift, NJ Ex Order 26 day shift and NJ Ex Order 26 day shift administrations were blank. NJ Ex Order 26.4(b)(1) [redacted] 2x/day for NJ Ex Order 26.4(for 14 Days. The NJ Ex Order 800 and 1700, NJ Ex Order 800 and 1700 and NJ Ex Order 26 800 and 1700 administrations were blank. Pain assessment to be completed every shift. The NJ Ex Order , NJ Ex Order and NJ Ex Order 26. day shift administrations were blank. A review of Resident #24's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) [redacted]). A review of Resident #24's NJ Ex Order 26.4(b)(1) eTAR included the following: NJ Ex Order 26.4(b)(1) [redacted] apply NJ Ex Order 26.4(b)(1) [redacted] then NJ Ex Order 26.4(b)(1). And NJ Ex Orde with NJ Ex Order 26.4(b)(1) daily and PRN (as needed) every day shift. The NJ Ex Order day shift administration was blank.	F0658		

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F0658 SS = D	Continued from page 17 NJ Ex Order 26.4(b)(1) every shift for promote NJ Ex Order 26.4(b)(1). The NJ Ex Order day shift and NJ Ex Order 26. night shift administration was blank. Assess resident for the following symptoms: NJ Ex Order [redacted]. Document "YES" if symptoms are noted, notify MD and follow up with a PN every shift. The NJ Ex Order 2 day shift and NJ Ex Order 26. night shift administration was blank. NJ Ex Order 26.4(b)(1) [redacted] to NJ Ex Order [redacted]. The NJ Ex Order 2 1700 and the NJ Ex Order 800 and 1700 administration times were blank. NJ Ex O assessment to be completed every shift. The NJ Ex Order day shift and NJ Ex Order 26. night shift administration was blank. A review of Resident #31's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) [redacted]), and NJ Ex Order 2 [redacted]). A review of Resident #24's NJ Ex Order 26.4(b)(1) eTAR included the following: Assess resident for the following symptoms: NJ Ex Order [redacted]. Document "YES" if symptoms are noted, notify MD and follow up with a progress note every shift. The NJ Ex Order day shift, NJ Ex Order day shift and NJ Ex Order 26. day shift administrations were blank. On 8/19/25 at 10:49 AM, S31 interviewed LPN #1 regarding omissions on the resident's eTAR. LPN #1 stated that if there was an order to be carried out on her shift on the eTAR that it was expected to be done. S#1 showed LPN #1 one of the resident's eTAR that had multiple omissions and LPN #1 stated that there should not be any blanks. On 8/19/25 at 11:03 AM, S#1 interviewed the U.S. FOIA regarding omissions on the resident's eTAR. The U.S. FOIA stated that her expectation would be that there were no omissions. On 8/19/25 at 2:20 PM, S#1 notified the U.S. FOIA (b) (6)	F0658		

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F0658 SS = D	Continued from page 18 U.S. FOIA (b) (6)) and U.S. FOIA the concern that there were omissions on the eTAR for Residents #5, #24, and #31. On 8/20/25 at 1:16 PM, S#1 met with the U.S. FOIA (and U.S. FOIA for a response to the concern. The U.S. FOIA (and U.S. FOIA did not have a response. The U.S. FOIA (and U.S. FOIA did not provide any additional information. A review of the undated facility's “Physician Medication Orders Policy” did not include information regarding administration and omissions. 3.On 8/14/25 at 10:58 AM, S#2 observed Resident #62 in their room, NJ Ex Order 26.4(b)(1) and NJ Exec Order 26.4b1 with a NJ Exec O The resident did NJ Exec Order 26.4b1 with their care and stated they liked NJ Exec Ord in their room. On 8/18/25 at 9:45 AM, S#2 reviewed the Electronic Medical Record (EMR) of Resident #62. A review of the AR reflected that Resident #62 had diagnoses that included but were not limited to; NJ Ex Order , NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)). A review of the cMDS, with an ARD of NJ Ex Order 26, reflected a BIMS score of N out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) . A review of the physician’s order revealed: NJ Ex Order 26.4(b)(1), give 1 tab by mouth at bedtime (HS) for NJ Ex Order 26.4(b) The order was discontinued (d/c'd) on NJ Ex Order . NJ Ex Order 26.4(b)(1) tab by mouth OD for NJ Ex Order 26.4(b)(1) was started on NJ Ex Order 2 and d/c'd on NJ Ex Order 26 . The NJ Ex Order 26.4(b) eMAR revealed the nurses signed ‘NJ’ for the NJ Ex Order 26.4(b) med entry on NJ Ex Order 26, NJ Ex Order 26, NJ Ex Order 26, and NJ Ex Order 26, which indicated the resident NJ Exec Order the med. The entries NJ Ex Order 26.4(b)(NJ Ex Order 26 , NJ Ex Order 26 , NJ Ex Order 26 , and NJ Ex Order 26 were signed by the nurses as administered to the resident. The NJ Ex Order 26.4(b)(1) eTAR revealed the nurses signed ‘NJ Exe for the NJ Ex Order 26.4(b) med entry on NJ Ex Order , which indicated other/see PN. The entries from NJ Ex Order to NJ Ex Order were	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315525	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0658 SS = D	Continued from page 19 signed by the nurses as administered to the resident. A PN dated 8/1/25 at 10:06 PM by the nurse indicated the resident NJ Exec Order all due meds, was NJ Ex Order 26 , did not want NJ Ex Order their room, and the resident was NJ Ex Order 26.4(b) with no success. A PN dated NJ Ex Order at 6 PM indicated the resident NJ Exec Order to take their NJ Ex Order med when offered, NJ Exec Orc their NJ Exec O at staff and NJ Exec Order 26.4(b) to NJ E the staff. Two different nurses attempted to administer the med to resident at different times and Resident #62 continued to NJ Exec Orc the med; the family and the physician was made aware. Further review of PN in NJ Ex Order 26.4(b and NJ Ex Order 26.4(b)(1), revealed the resident NJ Exec Order meds on multiple occasions. A PN dated NJ Ex Order 26.4 note documented "Patient received NJ Ex Orc in room but NJ Ex Order 26.4(b)(1) out of drawers and closet. Receptive to NJ Exec Order 26.4(b)(1) Patient visible on the unit NJ Exec Orde in the hallway with NJ Ex Order NJ Exe with the use of NJ Exec O Compliant with med after repeated prompting. NJ Exec Order 2 NJ Ex Order 26.4(b)(despite nursing education. NJ Ex Order 26.4(b)(1). [primary physician] notified. Encouraged patient to sit in day room amongst peers and watch TV (television) however patient NJ Exec Order 2 Advised patient to NJ Ex Order 26.4(b)(1) in control. " There was no documentation regarding the discontinuation of the resident's NJ Ex Order 26.4 or NJ Ex Order 26.4(b med in the PN. On 8/18/25 at 11:59 AM, S#2 interviewed LPN #2 who was assigned to care for Resident #62. LPN #2 stated the resident did have a history of NJ Exec Order2 med and NJ Ex Order 26.4(b)(1) LPN#2 explained that she spoke with Resident #62 NJ Ex Order 26.4(b)(to make them more comfortable, and explained the importance of the med or procedure, such as NJ Ex Order 26.4(b)(1 to be administered. LPN #2 stated that the resident was NJ Ex Order 26.4(b)(1) on her shift. S#2 asked LPN #2 about the resident's med of NJ Ex Order 26.4 and NJ Ex Order 26.4(b) LPN#2 stated Resident #62 was seen by the NJ Ex Order 26.4(b)(1) who recommended to d/c the med and it was. S#2 reviewed with LPN#2 a consult note in the resident's chart. LPN#2 stated the consult was from NJ Ex Order 26.4(b) who recommended the NJ Ex Order 26.4 med to be started. LPN#2 further explained the NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(1) decided their recommendations and the primary physician d/c'd the meds. S#2 asked LPN#2	F0658		

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F0658 SS = D	Continued from page 20 where the most recent NJ Ex Order 26.4(b)(consultant note would be found. LPN #2 was not sure and stated it may be by the other nurses' station. On 8/18/25 12:11 PM, S#2 interviewed LPN #1, who stated the NJ Ex Order 26.4(b)(consultants left their notes in the resident's hard copy chart or would scan it into the EMR. On 8/18/25 at 12:12 PM, S#2 interviewed the U.S. FOIA who stated NJ Ex Order 26.4(b) consultants uploaded their notes into the miscellaneous section of the EMR. S#2 asked about Resident #62's NJ Ex Order 26.4 med, the U.S. FOIA stated the NJ Ex Order 26.4(b) consultant recommended NJ Ex Order 26.4 for the resident which was started. The U.S. FOIA stated NJ Ex Order 26.4(b) was consulted who recommended that the NJ Ex Order 26.4 be d/c'd as the diagnosis and the indication was not appropriate for the resident. S#2 asked the U.S. FOIA about the resident's NJ Ex Order 26.4(b) med which was also noted as d/c'd. The U.S. FOIA stated the NJ Ex Order 26.4(b) med was d/c'd as per physician's orders. S#2 asked the U.S. FOIA for the most recent NJ Ex Order 26.4(b)(consultant note which was not found when reviewing the EMR and the hard copy chart. On 8/19/25 at 1:30 PM, S#2 reviewed the NJ Ex Order 26.4(b)(consultant note, dated NJ Ex Order 26, in the EMR. The note revealed the consultant was requested to evaluate the resident due to the NJ Ex Order 26.4(b) consult recommendation for NJ Ex Order 26.4(The consultant recommended that the NJ Ex Order 26.4 med be d/c'd, to monitor the resident's NJ Ex Orde and NJ Ex Order 26.4(report concerns, to continue NJ Ex Order 26.4(b)(1) by mouth at HS for NJ Ex Order 26.4(b) and to continue the NJ Ex Order 26.4(b)(1)). Further review of EMR did not reveal documentation of why the resident's NJ Ex Order 26.4(b) was d/c'd. On 8/19/25 at 2:15 PM, S#2 notified the U.S. FOIA (and the U.S. FOIA about the concern of no documentation regarding why Resident #62's NJ Ex Order 26.4(b) med was d/c'd and the NJ Ex Order 26.4(b)(consultant recommending to continue the med. On 8/20/25 at 8:30 AM, the surveyor reviewed the facility provided physician progress note (PPN) with an effective date of NJ Ex Order 26, written by the primary physician. The PPN documented the resident was NJ Ex Order at times with meds and with NJ Ex Order 26.4(The physician indicated the NJ Ex Order 26.4(b) was d/c'd due to resident NJ Exec Order 26.4b1 and that the med was NJ Ex On 8/20/25 at 8:59 AM, the U.S. FOIA provided the "Charting/Documenting Policy" to the survey team.	F0658		

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F0658 SS = D	Continued from page 21 On 8/20/25 at 1:06 PM, the U.S. FOIA (I and the U.S. FOIA met with the survey team. The U.S. FOIA stated that the PPN was provided to the surveyor. The U.S. FOIA explained the med was d/c'd by the primary physician as the resident had NJ Exec Order 26 of NJ Exec Order 2 the med and it was NJ Exec Order 26.4b1 the resident as much. S#2 asked the U.S. FOIA who received the order from the physician to d/c the NJ Ex Order 26.4(b med. The U.S. FOIA replied that she was the one who received the order from the physician. S#2 asked the U.S. FOIA if it was expected for staff to document when clarifying orders and recommended meds with the physician. The U.S. FOIA stated it was expected for it to be documented in the EMR. The U.S. FOIA acknowledged there was no additional documentation in the medical records by the nurses or physician regarding the discontinuation of the NJ Ex Order 26.4(b med. S#2 requested any policy physician consultants/consultant recommendations. On 8/21/25 at 11:00 AM, the U.S. FOIA informed the surveyors the facility did not have a policy related to physician consultants or their recommendations. A review of the facility's "Charting/Documenting Policy", which was undated, revealed under Procedure:…Chart all pertinent changes in the resident/patient/'s condition, reaction to treatment, med, etc., as well as routine observations…Documentation should also include…Any time a physician or family is called about the resident/patent as well as their response…Each time a physician visits the resident/patient and writes orders… NJAC 8:39-27.1(a)	F0658		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that	F0684	Element I Resident #8's medication regimen has been clarified with the NJ Ex Order 26.4(b)(1) and primary physician. Documentation of the NJ Ex Order 26.4(b)(1) recommendation regarding NJ Ex Order 26.4(b)(administration has been entered into the Electronic Medical Record and the care plan has been updated. Element II All residents receiving tube feedings and medications via g-tube were reviewed. No other residents were found to have medications administered in a manner inconsistent with manufacturer guidelines.	09/05/2025

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F0684 SS = D	Continued from page 22 a resident receive treatment and care in accordance with professional standards of practice and facility policies and procedures with regard to NJ Ex Order 26.4(b)(1) for 1 of 3 residents (Resident #8) reviewed. The deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/18/25 at 12:12 PM, the surveyor observed NJ Ex Order 2 signage and personal protective equipment (PPE) by the doorway and NJ Ex Order 26.4(b)(1) in the room. Resident #8 was sitting on a wheelchair watching television. A review of the Admission Record (an admission summary) revealed diagnoses which included but not limited to; encounter for NJ Ex Order 26.4(b)(1) following NJ Ex Order 26 on the NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)), NJ Ex Or), NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b) , NJ Ex Order 26.4(b)(1)). A review of the quarterly minimum data set (MDS), an assessment tool which facilitates the plan of care, with an assessment reference date (ARD) of NJ Ex Order 2	F0684	Continued from page 22 Element III Staff re-educated on safe medication administration practices, including following manufacturer guidelines and consulting with pharmacy/physician when medications are not appropriate for crushing or g-tube use. Pharmacy consultant recommendations will be reviewed, documented, and acted upon promptly. A new “Medication Clarification Protocol” was implemented requiring nurses to immediately notify the physician and document follow-up when pharmacy identifies concerns. The Director of Nursing or designee will conduct weekly audits for 4 weeks then bi-weekly x2 months then monthly for 3 months of medication administration records for 2 residents on g-tube feedings, ensuring adherence to manufacturer guidelines and timely physician/pharmacy communication. Element IV Results of the audit will be presented to the Quality Assessment and Assurance Committee during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting. Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting.	

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F0684 SS = D	Continued from page 23 revealed a brief interview of mental status (BIMS) score of [redacted] out of 15, indicating [redacted]; and [redacted] was coded. A review of the physician orders revealed the following: [redacted]. Start at 4:00 PM and discontinue (d/c) at 12 PM or until [redacted]. ([redacted] in the evening and remove per schedule, revised [redacted] [redacted], [redacted], [redacted] Check placement of the [redacted] prior to medication (med) administration. [redacted] with a minimum of [redacted] prior to and immediately after med administration every shift for [redacted] [redacted] (tab) ER [redacted]), give 1 tab by mouth every 12 hours for [redacted] ordered [redacted], end date [redacted] [redacted] Tab 12 Hour [redacted] give 1 tab via [redacted] every 12 hours for [redacted], ordered [redacted], end date [redacted] [redacted] Tab 12 Hour [redacted], give 1 tab by mouth every 12 hours for [redacted] ordered [redacted], end date [redacted] [redacted] Tab 12 Hour [redacted] give 1 tab via [redacted] every 12 hours for [redacted], ordered [redacted], end date [redacted] [redacted] Tab 12 Hour [redacted], give 1 tab by mouth every 12 hours for [redacted], ordered [redacted] end date [redacted] [redacted] Tab 12 Hour [redacted] give 1 tab via [redacted] every 12 hours for [redacted] order revised [redacted] A review of the med [redacted] manufacturer label for dosage and administration-dosing information reflects, "Take [redacted] with or without meals. [redacted] tablets whole; do not crush, break, or chew."	F0684		

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F0684 SS = D	Continued from page 24 A review of the resident's care plans revealed: • requires NJ Ex Order 26.4(b)(1) r/t (related to) NJ Ex Order Date Initiated: NJ Ex Order 26 Created on: NJ Ex Order 26 Created by: (U.S. FOIA (b) (6)) Revision on: NJ Ex Order 26 Revision by: (U.S. FOIA (b) (6)). • requires NJ Ex Order 26.4(b)(1) Date Initiated: NJ Ex Order 26 Created on: NJ Ex Order 26 Created by: (U.S. FOIA (b) (6)) Revision on: NJ Exec Order Revision by: (U.S. FOIA (b) (6) On 8/19/25 at 12:12 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1), who stated that the resident had NJ Ex Order 26.4(b)(1) in the past, was NJ Exec O did a NJ Ex Order 26.4(b)(1) LPN #1 stated that the resident had an order for NJ Ex Order 26.4(b), the NJ Ex Order 2 on at 4 PM, NJ Ex Order 26.4(b)(1) LPN #1 further stated that meds were crushed via NJ Ex LPN #1 added that med NJ Ex Order 26.4(b)(1) "I know I cannot crush", and "I" put the pill whole in water in a cup of 5 ml, and dissolved. LPN #1 indicated that there was no other med to administer and that the resident needed the med for resident's NJ Ex Order 2 LPN #1 confirmed that night shift nurses did the same thing for NJ Ex Order 26.4(b)(1) dissolved in water in order to administer the med. At that same time, LPN#1 informed the surveyor that "we" asked pharmacy to change the med and the resident had NJ Ex Order 26.4(b)(1). The surveyor asked LPN #1 should there had been a clarification with the U.S. FOIA (b) (6) and the LPN replied, "To be honest, I never called, there should have been a phone call. The primary doctor told me to reach the NJ Ex Order 26.4(b)(1) LPN #1 stated that the resident did not have incident of NJ Ex Order 2 On 8/19/25 at 12:20 PM, the surveyor reviewed the pharmacy consultant monthly medication review (MMR) from NJ Ex Order 26.4(b)(1), and revealed: Recommendations for NJ Ex Order 26.4 #4 Do not crush NJ Ex Order 26.4(b)(1 Please review for an alternative. No action taken. Recommendations for NJ Ex Order 26.4 #8 Do not crush NJ Ex Order 26.4(b)(1 Please review for an alternative. Nurse signature U.S. FOIA (b) (6)) signed dated NJ Ex Order 26. Recommendations for NJ Ex Order 26, #16 Do not crush NJ Ex Order 26.4 Consider contacting physician for alternatives such as NJ Ex Order 26.4(b)(1). "Action taken: In the hospital." (Resident was sent to the hospital on NJ Ex Order 26.	F0684		

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F0684 SS = D	Continued from page 25 Recommendations for NJ Ex Order 26.4 #4 Do not crush NJ Ex Order 26.4(b)(1) Please review for an alternative. Signed by U.S. FOIA (b) (6) on NJ Ex Order 26 Recommendations for NJ Ex Order 26, Do not crush NJ Ex Order 26.4 Consider alternative for NJ Ex Order 26.4(b)(1). No action taken. Recommendations for NJ Ex Order 2 Do not crush NJ Ex Order 26.4 Consider alternative for NJ Ex Order 26.4(b)(1) -Needs NJ Ex Order 26.4(b) On 8/19/25 at 12:33 PM, the U.S. FOIA (b) (6)) informed the surveyor that she contacted the pharmacist to verify if there was a med that equal to NJ Ex Order 26.4 and was advised that NJ Ex Order 26.4 was the med that can be used. The U.S. FO further stated that when she called the doctor, the doctor told the U.S. FO that the resident should be seen by the U.S. FOIA (b) (6) for med changes. The U.S. FO was unsure if NJ Ex Order 26.4(b)(1) appointment was set up and was unsure as to why there was no NJ Ex Order 26.4(b) appointment in the resident's chart. The U.S. FO also stated that there should had been a call to the U.S. FOIA (b) (6) to clarify this order. On 8/19/25 at 2:32 PM, the surveyor notified the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) regarding the concern with NJ Ex Order 26.4(b)(ER administration. The U.S. FOIA replied that the resident was seen by the U.S. FOIA (b) (6) last year in NJ Exec Order 26.4b1 and the recommendation was to follow up in three months. The U.S. FOIA stated that the order should have been clarified. On 8/20/25 at1:07 PM, the survey team met with the U.S. FOIA (and the U.S. FOIA and the U.S. FOIA stated that "we" consulted with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) after surveyor's inquiry about the concern with NJ Ex Order 26.4(b)(ER, the resident had no occurrence of NJ Ex Order 2 and both the U.S. FOIA and the U.S. FOIA (b) (6) were aware of the manufacturer's information, both decided to continue to administer the med after dissolving to water. A review of the NJ Ex Order 26 note, after surveyor inquiry, from the U.S. FOIA (b) (6) which revealed, “Patient has been on NJ Ex Order 26 since developing NJ Ex Order 26.4(b) on NJ Ex Order 26.4(b). It was felt in spite of NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)) administration, since it had NJ Exec Order 26.4 (patient’s) NJ Exec Order 26.4 it should be continued." On 8/21/25 at 11:00 AM, the U.S. FOIA stated to the survey	F0684		

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F0684 SS = D	Continued from page 26 team that the facility did not have a policy on contactor/consultants. NJAC 8.39-27.1(a)	F0684		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a resident who did not have a NJ Ex Order 26.4(b)(1)) upon admission and who was identified at risk of developing a NJ Ex O received care and services in accordance with professional standards of practice to prevent NJ Ex Or Resident #7 developed a facility acquired NJ Ex Order 26.4(b)(1) identified by the Certified Nursing Aide and NJ Ex Order 26.4(b)(1) identified during NJ Ex Order consultation (both four days after admission). In addition, the facility failed to ensure treatments were ordered at the time of identification. The resident's NJ Ex Order 26 worsened, developed a NJ Ex Order 26.4(b)(1), and had undergone NJ Ex Order 26.4(b)(1) . This deficient practice was identified for 1 of 2 residents (Resident #7) reviewed for NJ Ex Order 26.4(b)(1). The deficient practice was evidenced by the following: According to the National Pressure Ulcer Advisory Panel (NPUAP), April 13, 2016, the updated staging system includes the following definitions:	F0686	Resident #7 was immediately reassessed on 8.19.25 by the Director of Nursing and the primary physician was notified of the findings with no new orders needed. NJ Ex Order 2 assessments were reviewed and are documented as per physician orders in the electronic health record. The care plan was reviewed updated to include NJ Ex Order 26.4(b)(1) strategies for each NJ Ex Order 2 Staff that provide care to resident 7 were re-educated about the residents' current preventative measures modified in the care plan. The Infection Preventionist completed an audit for accuracy of physician wound assessment and wound care treatment orders on 08.20.2025 for residents with pressure injuries. Care plans were reviewed and revised as needed to ensure current physician orders related to wound care and treatment orders were transcribed and skin assessments completed & documented as ordered. The Director of Nursing completed in-service education on 8.20.2025 with the infection preventionist and the direct nursing staff to ensure facility policy and procedures related to skin integrity, including the assessment, prevention and treatment of pressure related injuries are reviewed in accordance with all state and federal requirements. The Infection preventionist created a Quality Assurance Performance Improvement Plan and presented her findings to the Director of Nursing on 8.21.2025 to ensure facility policy and procedures were followed related to the wound assessment, prevention and treatment of skin related conditions including pressure related to skin conditions. Any findings were immediately addressed. Element II – Identification of at Risk Residents Residents with NJ Exec alterations and/or NJ Exec Order 26 including resident # 7 have the potential to be affected by the deficient practice. The Director of Nursing and/or designee will ensure NJ Exec Orde care and treatment policy and procedures are followed by nursing staff in accordance with the state and federal requirements by conducting NJ Exec Order 26.4b1	08/25/2025

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F0686 SS = G	Continued from page 27 Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear…Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin…Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister…These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD)…or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin…Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur…Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur…Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed…Deep Tissue Injury (DTI): Persistent non-blanchable deep red, maroon or purple discoloration…or blood filled blister…This injury results from intense and/or prolonged pressure and shear forces at the bone[1]muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4)… Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems,	F0686	Continued from page 27 audits. Chart audits of the residents were completed immediately and no new findings related to the deficient practice and no adverse outcomes were noted. Element III – Systemic Change The Director of Nursing re-educated the Infection Preventionist and the direct care nursing staff on the wound assessment flow sheet to maintain compliance with physicians' treatment orders, implementation of interventions, care plan revisions, and family notification on 8.20.2025. Director of Nursing or designee will randomly select three residents with pressure injury weekly for four weeks and then bi-weekly for one month and then monthly for four months thereafter. The audit tool will include care plan review and revision, wound assessment review, wound documentation, and accuracy of wound care treatment/interventions. Refresher training is available a minimum of quarterly for nursing direct care staff on “Pressure Ulcer Prevention and Management Policy.” Training includes Resident assessment on admission, re-admission, and quarterly thereafter for risk factors associated with pressure ulcer development, the necessary precautions to prevent formation and wound care treatment to promote healing. Appropriate interventions will be addressed to prevent pressure ulcer development and to promote healing when ulcers are present. Element IV- Quality Assurance Results of the pressure injury audits will be presented and reviewed to the Administrator and Quality Assurance and Performance Improvement Committee for weekly X four weeks, bi-weekly for one month and then monthly for four months thereafter during the meetings for action as appropriate. These corrective actions will be monitored by the administrator through the Quality Assurance and Performance Improvement Committee to ensure effectiveness and continual compliance for a period of four months then re-evaluated as needed.	

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F0686 SS = G	Continued from page 28 through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/14/25 at 10:03 AM, Surveyor #1 (S#1) met with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6)) during entrance conference and asked for the facility's list of residents with NJ Ex Order 26.4(b)(1). On 8/14/25 at 10:25 AM, S#1 observed an NJ Ex Order 26.4(b) signage outside Resident #7's room. Resident #7 was awake, lying on an NJ Exec Order 26.4b1, with NJ Ex Order 26.4(b)(1) on the side of the bed contained within NJ Ex Order 26.4(b)(1) At that same time, Resident #7 informed S#1 that they had NJ Ex Order 26.4(b)(1) and had been at the facility for NJ Ex Order 26.4(b)(1). The resident stated that they had NJ Ex Order 26.4(b)(1) their NJ Ex Order 26.4(b)(1). The resident further stated that the U.S. FOIA (b) (6)) came that morning and NJ Ex Order 26.4 the NJ Ex Order 26.4(b)(1) On 8/14/25 at 11:08 AM, the U.S. FOIA (b) (6)) informed S#1 that Resident #7's NJ Ex Order 26 were NJ Ex Order 26 S#1 reviewed the medical records of Resident #7, which revealed the following: According to the Admission Record or face sheet (an admission summary) Resident #7 was admitted to the facility with diagnoses which included but not limited to; NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1)),	F0686		

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F0686 SS = G	Continued from page 29 NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1), and NJ Ex Order 26.4(b)(1). A review of the hospital records, with an attestation by a physician dated NJ Ex Order 26 at 9:02 AM, revealed that the resident was seen and evaluated at the bedside and the resident's NJ Ex O had NJ Ex Order 26.4(b)(1). The hospital notes did not include any information that the resident was on NJ Ex O and/or NJ Ex Order 26.4(b)(1) treatment upon discharge (d/c) from the hospital. A review of the "Admission Summary" completed by Licensed Practical Nurse #1 (LPN #1) in the electronic health system (EHR) dated NJ Ex Order 26. at 6:57 PM, revealed, "Resident arrived via stretcher from [hospital name]. No NJ Ex Order 26 noted on NJ Ex Orde A review of the "Admission Assessment," revealed that the resident was admitted to the facility with NJ Ex Order 26.4(b)(1) was NJ Ex Order 26.4(had no NJ Ex Order 26.4(b)(1), no NJ Ex Order 26.4(b)(1), and the preventative approaches/equipment included NJ Ex Order 26.4(b)(1) program. The NJ Ex Order 2 Scale for NJ Ex Order 26.4(b) score upon admission was NJ Ex Orde. A review of Resident #7's Progress Notes (PN) revealed: A Physician History & Physical Exam, with an effective date of NJ Ex Order 26, that was electronically signed by the Medical Doctor (MD), reflected that resident's NJ Ex O was NJ Ex Order 26. A Late Entry: Health Status Note (HSN) with an effective date of NJ Ex Order 26, created on NJ Ex Order 26.4 that was electronically signed by previous U.S. FOIA (b) (6) reflected that the U.S. FOIA reported the resident having an opening to the NJ Ex Order 26. The nurse assessed, no c/o (complaint of) NJ Ex Ord NJ Exec Order 26. with NJ Ex Order 26.4(b)(1)), applied NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1). Notified the MD and ordered NJ Ex Order 26.4(b)(1). A NJ Ex Order 26.4(b)(1) Note with effective date o NJ Ex Order 26.4 that was electronically signed by the U.S. FOIA (b) reflected an NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) and with new order for NJ Ex O	F0686		

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F0686 SS = G	Continued from page 30 A Health Status Note (HSN) with effective date of [redacted], that was electronically signed by Licensed Practical Nurse #2 (LPN#2), reflected that resident's [redacted] was found with [redacted] was brought down to the 1st floor but was not working, a [redacted] was tried and was not working, and the [redacted] were left on the 8th floor [redacted] Further review of the PN revealed that there was no other documentation that a [redacted] was provided to the resident. A review of the [redacted] Consult Notes for Resident #7 revealed: Date of service (DOS): [redacted] the resident presented with: [redacted] with [redacted] and tx (treatment) plan: [redacted] apply once daily (OD) and PRN (as needed) ; [redacted], and tx plan: [redacted] apply OD and PRN. General recommendations: [redacted]. DOS: [redacted] the resident presented with: [redacted] OD and PRN. [redacted] procedure and removed [redacted], and tx plan: [redacted] apply OD and PRN: [redacted], and tx plan: [redacted] apply OD and PRN. DOS: [redacted] the resident presented with: [redacted] apply OD and PRN. To residual [redacted] along [redacted] edge, [redacted] apply OD and PRN. [redacted] assessment of this previously [redacted] had revealed	F0686		

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F0686 SS = G	Continued from page 31 the NJ Ex Order 26.4(b)(1) at the NJ Ex Order 26.4(b)(1) [redacted]) and NJ Ex Order 26.4(b)(1) [redacted], and tx plan: NJ Ex Order 26.4(apply OD and PRN; NJ Ex Order 26.4(b)(1) [redacted], and tx plan: NJ Ex Order 26.4(apply OD and PRN. DOS: NJ Ex Order 26, the resident presented with: NJ Ex Order 26.4(b)(1) [redacted] and tx plan: NJ Ex Order apply OD and PRN. To NJ Ex Order 26.4(b)(1) [redacted] apply OD and PRN; NJ Ex Order 26.4(b)(1) [redacted], and tx plan: NJ Ex Order 26.4(apply OD and PRN; NJ Ex Order 26.4(b)(1) [redacted], and tx plan: NJ Ex Order 26.4(apply OD and PRN. DOS: NJ Ex Order 26.4(b)(1) company), the resident presented with: NJ Ex Order 26.4(b)(1) [redacted]), and tx plan: NJ Ex Order 26.4(b)(1) [redacted] change twice a day (BID) and PRN. NJ Ex Order 26.4(b)(1) [redacted] and tx plan: NJ Ex Order 26.4(b)(1) [redacted], change daily and PRN. NJ Ex Order 26.4(b)(1) [redacted]. The recommendations for NJ Ex Order care continued NJ Ex Or and NJ Ex Order 26, for the following: NJ Ex Order 26.4(b)(1) [redacted] tx plan: NJ Ex Order 26.4(b)(1) [redacted] daily and PRN. NJ Ex Order 26.4(b)(1) [redacted] procedure done; NJ Ex Order 26.4(b)(1) [redacted] tx plan: NJ Ex Order 26.4(b)(1) [redacted] daily and PRN NJ Ex Order 26.4(b)(1) [redacted];	F0686		

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F0686 SS = G	Continued from page 32 NJ Ex Order 26.4(b)(1) tx plan: NJ Ex Order 26 daily and PRN. NJ Ex Order 26.4(b)(1) tx plan: NJ Ex Order 26.4(b)(1) daily and PRN. Frequent NJ Ex Order 26.4(b)(1) DOS: NJ Ex Order 26, the resident presented with: NJ Ex Order 26.4(b)(1) and tx plan: NJ Ex Order 26.4(b)(1) daily and PRN. Other to NJ Ex Order 26.4(b)(1) parts of NJ Ex Order 26.4(b)(1) procedure done; NJ Ex Order 26.4(b)(1)), tx plan: NJ Ex Order 26.4(b)(1) daily and PRN. NJ Ex Order 26.4(b)(1) , tx plan: NJ Ex Order 26.4(b)(1) daily and PRN. NJ Ex Order 26.4(b)(1) tx plan: NJ Ex Order 26.4(b)(1) daily and PRN. Frequent NJ Ex Order 26.4(b)(1) . DOS: NJ Ex O and NJ Ex Order 26.4(b)(1 same NJ Ex Order care recommendations as above NJ Ex Order 26.). A review of Resident #7's Order Audit Report included but was not limited to; NJ Ex Order 26.4(b)(1 was ordered to NJ Ex Order 26 on NJ Ex Order 26. and not on NJ Ex Order 26 , when identified in the NJ Ex Order 26 PN. NJ Ex Order 26.4(b)(1 were ordered on NJ Ex Order 26.4 and not on NJ Ex Order 26. NJ Ex Order 26.4(b)(1) was ordered on NJ Ex Order , and not on NJ Ex Order 26. NJ Ex Order 26.4(b)(1) was ordered on NJ Ex Order 26 and not on NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1) was ordered on NJ Ex Order 26. , and not on NJ Ex Order 2	F0686		

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F0686 SS = G	Continued from page 33 A review of Resident #7's Treatment Administration Record (eTAR) from NJ Ex Order 26.4(b)(1), and signed by nurses confirmed the above orders. In addition, there was no documented evidence that the recommendation for limit sitting to 60 minutes out of bed were followed. A review of Resident #7's Weekly NJ Ex Or Assessments revealed; Effective Date: NJ Ex Order 26. at 6:02 PM, NJ Ex Order 26.4(b)(1) noted. Effective NJ Ex Order 26 at 8:31 AM, NJ Ex Order 26.4(b)(1) . Effective NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4 NJ Ex Order 26.4(b)(1) was observed. There was no documented evidence that NJ Ex Order 26.4(b)(1) were identified in the assessment. Effective NJ Ex Order 26.4(, and NJ Ex Order 2 , observed NJ Ex Order 26.4(b)(1) . There was no documented evidence that the NJ Ex Order 26.4(b)(1) was identified in the assessment. A review of the modified (corrected) comprehensive Minimum Data Set (MDS), an assessment tool that facilitates the management of care, with an assessment reference date (ARD) of NJ Ex Order 26 , reflected that the resident had a Brief Interview of Mental Status (BIMS) score of NJ E out of 15, indicating NJ Ex Order 26.4(b)(1) . The MDS revealed that the resident was coded for NJ Ex Order 26.4 with NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1) . The MDS also reflected that the resident had NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and had NJ Ex Ord). A review of Resident #7's care plans revealed; The resident had NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26 r/t (related to NJ Ex Order 26.4(b)(1) (created on NJ Ex Order 26); The resident was resistive to care with NJ Ex Order 26.4(b)(1) (created on NJ Ex Order 26.4 The resident had NJ Ex Order 26.4(b)(1) of the NJ Ex Order 26.4(b)(1) (created NJ Ex Order 26 and revised on NJ Ex Order 26); The resident had NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1)	F0686		

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F0686 SS = G	Continued from page 34 NJ Ex Order 26.4(b)(1) (created NJ Ex Order 26 and revised on NJ Ex Order 26.4(b The resident was NJ Exec Order 2 to care and recommendations such as; use of NJ Ex Order 26.4(b)(1) (created on NJ Ex Order 26 and revised on NJ Ex Order 26); Risk for further NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)((created or NJ Ex Order 26.4(b There were no care plans initiated with interventions upon admission for the resident's risk of NJ Ex O or at the time the resident was identified with the NJ Ex Order 26.4(b)(1)) and NJ Ex Order 26.4(b)(1) On 8/18/25 at 8:15 AM, the U.S. FOIA (b) (6) provided a copy of facility acquired NJ Ex Order 26 and revealed that Resident #7 was on the list for NJ Ex Order 26.4(b)(1) , and NJ Ex On 8/19/25 at 9:35 AM, the resident NJ Exec Order 2 NJ Ex Order 26.4(b)(tx observation. On 8/19/25 at 11:38 AM, S#1 interviewed LPN #3 regarding the process for NJ Ex Order care, and LPN #3 stated that the resident had NJ Ex Order 26.4(b)(1) , and they were not NJ Ex Order 26.4(b)(1). LPN#3 was unable to provide documentation that Resident #7's NJ Ex Order 26 were not NJ Ex Order 26.4(b)(1). On 8/20/25 at 10:12 AM, the U.S. FOIA (b) (6)) informed S#1 that the initial comprehensive MDS was modified on NJ Ex Order 26, to reflect that the resident had NJ Ex Order 26.4(b)(that were NJ Ex Order 26.4(b)(1) according to the NJ Ex Order 26.4(b)(1) notes that were uploaded late (NJ Ex Order notes NJ Ex Order 26 was uploaded NJ Ex Order 2. On 8/20/25 at 11:28 AM, S#1 interviewed LPN #2 regarding the process for admission. LPN#2 informed S#1 that as facility practice, when a resident was admitted, an assessment would be done that included a NJ Ex O assessment. He stated that the NJ Ex O assessment would include the NJ Ex Order 2 scale, whether the NJ Ex O was intact or not, and then a preventative order would be put in place. He further stated that it would be the U.S. FOIA (b) (6)) or the U.S. FOIA who would initiate the CP, and a nurse would verify with the doctor on what tx to order. He also added that there was a contractor who comes to the facility every Thursday to do NJ Ex Order rounds, and every week, "we" re-evaluate NJ Ex Order 26.4(b)(on shower days, and "I" look at it every day. On that same date and time, LPN #2 informed S #1 that	F0686		

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F0686 SS = G	Continued from page 35 Resident #7 came in with NJ Ex Order 26.4(b)(1) and was unsure about the NJ Ex Order 26.4(b)(1). S #1 asked if he recalled on admission resident's NJ Ex O and if any tx was ordered and he responded, "I'm not sure." On 8/20/25 at 11:44 AM, the U.S. FOIA in presence the of the survey team confirmed that there was no documented evidence in the resident's medical records that the resident was admitted with NJ Ex Order 26.4(b)(1). She further stated that the nurse failed to capture the NJ Ex Order 26.4(b)(1) upon admission. The U.S. FOIA informed the survey team that there was an investigation that was initiated in May when the NJ Ex Order 26.4(b)(1) opened. On 8/20/25 at 12:00 PM, S#2 asked the U.S. FOIA for the NJ Ex Order 26.4(b)(1) investigation. A review of the provided "New Skin Issue" investigation that was provided by the NJ Ex Ord revealed that on NJ Ex Order 26.4 the CNA reported to the nurse that the resident had an NJ Ex Order 26.4(b)(1), assessment was done, the MD was notified and ordered NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). On 8/20/25 at 12:01 PM, S#1 interviewed the U.S. FOIA (b) regarding resident's NJ Ex Order 26.4 and she stated the resident had NJ Ex Order 26.4(b)(1) when "I saw that Thursday during NJ Ex Order rounds, it was NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) further stated that she did not see the resident's NJ Ex O on admission. At that same time, the U.S. FOIA (b) stated that if there was any tx from the hospital, it would be carried over to the facility, and if there was none, it meant the resident's NJ Ex Order 26.4(b)(1) On 8/20/25 at 1:24 PM, the survey team met with the U.S. FOIA (and U.S. FOIA and S#1 notified them of the above findings and concerns. On 8/21/25 at 9:09 AM, S#1 interviewed the U.S. FOIA (b regarding Resident #7's NJ Ex Order 26.4 The U.S. FOIA (b stated the resident came from the hospital with NJ Ex Orde and the nurse obtained an order from the MD for NJ Ex Order 26.4(b)(1) The U.S. FOIA (b further stated that subsequent visit of the NJ Ex O the order was changed to NJ Ex Order which NJ Ex Order 26.4(b)(1) . S#1 asked the U.S. FOIA (b if the resident had any tx or interventions upon admission, and he replied that the hospital did not have any tx orders for the resident. S#1 asked if the nurse obtained NJ Ex Order 26.4(b)(1) tx order would it be expected to be in the eTAR, and he replied yes. S#1 asked if any other interventions or preventative measures for NJ Ex Order 26.4(b)(1) were implemented upon admission for the resident. The U.S. FOIA (b	F0686		

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F0686 SS = G	Continued from page 36 stated that NJ Ex Order 26.4(b)(1) was ordered and had issues with the NJ Ex Order 26.4(b)(1), which he reported to the U.S. FOIA (b) and NJ Ex Order 26.4(b)(1) was ordered which the resident now had. He also stated that the documentation for an NJ Ex Order 26.4(b)(1) should be seen in the resident's CP and physician orders. At that same time, S#1 asked about the NJ Exec Orde consult and how soon would NJ Exec Orde recommendations be followed up after the consultant's visit. He stated that the same day NJ Ex Order 2 rounds were done, the recommendations would be reviewed and carried out. S#1 asked about recommendations from NJ Ex O for NJ Ex Order 26.4(b)(1) and why it was not carried out onto the eTAR, (not until NJ Ex Order) and he responded that he did not know what happened and could speak about it. On 8/21/25 at 9:18 AM, the U.S. FOIA (b stated that resident came in with NJ Ex Orde and NJ Ex Order 26.4(b)(1) but it was not documented by the nurses. He also stated that the U.S. FOIA (b and U.S. FOIA were responsible for putting in orders and completing NJ Ex Order rounds. On 8/21/25 at 11:00 AM, S#3 discussed with the U.S. FOIA the interview with the U.S. FOIA (b with regard to the NJ Exec Order 26.4(upon admission. The U.S. FOIA stated that the resident did have NJ Ex Order 26.4(b)(1), confirmed a few issues with NJ Ex Order 26.4(b)(1), and a new one was ordered. S#3 asked if there was any documentation that NJ Ex Order 26.4(b)(1) was in use in replacement of the broken one, and the U.S. FOIA replied there was no documentation on it. On 8/21/25 at 11:55 AM, the U.S. FOIA (b) (6)), U.S. FOIA (b) and the U.S. FOIA met with the survey team. The U.S. FOIA (b) stated they acknowledged some of the resident's tx orders were not carried over, "but we (the facility)" provided care for the resident, NJ Ex Order 2 care was provided, and NJ E and tx were in place." S#3 asked where it would be documented that a resident had NJ Ex Orde , and the U.S. FOIA replied that the NJ Ex Order 26.4(b)(1) would be documented in MD orders, and CP. S#3 asked if there were any additional responses and the U.S. FOIA U.S. FOIA (b) and U.S. FOIA (b) confirmed they had no additional responses. On 8/21/25 at 12:55 PM, S#3 received a return call from LPN #1, who confirmed that she completed the admission assessment. LPN#1 stated that when the resident was admitted, she was unable to do NJ Ex Orde assessment because the resident was NJ Ex Order 26.4(b)(1). She further explained that the resident was assessed afterwards, the NJ Ex O assessment was not done, and it was endorsed to the next shift. She clarified she worked the day shift and was not sure and did not know when or who	F0686		

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F0686 SS = G	Continued from page 37 completed the resident's [NJ Ex C] assessment. LPN #1 added she did remember that when she did the resident's next [NJ Ex C] assessment, "I mis-documented". S#3 asked if she would document when unable to perform an assessment, such as the [NJ Ex C] assessment for resident upon admission, and LPN #1 stated they "normally" would document but she did not that day. At that same time, LPN #1 stated afterward she found out the resident had [NJ Ex Order 20] and was receiving treatments. LPN #1 could not specify the specific timeline. S#3 asked if any interventions upon admission were implemented for the resident or preventative measures and LPN #1 stated she could not recall. LPN #1 further stated that if there were any interventions implemented, they would be documented in the electronic medical record, in the orders, and the nurse would write a PN. A review of the undated facility's "Pressure Ulcer Prevention and Management Policy" revealed, "it is the policy of this facility to assess all residents upon admission, re-admission, and quarterly thereafter for risk factors associated with pressure ulcer development and the necessary precautions to prevent formation. Appropriate interventions will be utilized to prevent pressure ulcer development and to promote healing when ulcers are present." Procedure:1. All residents will be assessed on admission, re-admission, if noted with significant change in condition, and quarterly thereafter for the risk of pressure ulcer formation using Braden scale. A CP will be developed for residents at risk for pressure ulcer development or for residents assessed for pressure ulcer. 2. During admission or readmission, an admission assessment will be completed by the admitting nurse for residents identified pressure ulcer or other wounds, ulcers and skin problems...6. The licensed nurse is responsible for implementing the pressure ulcer treatment protocol...9. A licensed nurse will check the ulcer daily during treatment to assure proper wound healing and to assess for signs and symptoms of infection and notify MD of any concerns. A review of the facility's "Interdisciplinary Care Planning Protocol Policy" that was provided by the U.S. FOIA (b) (6), with date of 5/25, revealed: All Admissions-Day of Admission:1. Nursing admission assessment completed on day of admission but in no event later than 24 hours of admission. 2.Nursing initiates interim CP-the interim CP must address all immediate care needs...Interdisciplinary Care	F0686		

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F0686 SS = G	Continued from page 38 Planning:..2. Nursing provides overview of medical and nursing care regimes. Nursing provides input especially r/t activities of daily living, skin... A review of the undated facility's "Charting/Documenting Policy" that was provided by the U.S. FOIA revealed, to provide guidelines to nursing in the requirements of documenting each resident's status in order to evaluate the need for care or services. The purpose of these guidelines is to ensure complete comprehensive and timely document and timely documentation of the resident's/patient's care, treatment, response to care, signs, symptoms, change of condition as well as the progress of the resident/patient...Procedure: Admitting nurse: documents on the PN, all observations regarding the admission, the resident's status and any special needs or circumstances identified. Completes admission assessment answering, all required information... NJAC 8:39-27. (a)(e)	F0686		
F0730 SS = E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(e)(7) §483.35(e)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility provided documentation, it was determined that the facility failed to ensure that the Certified Nursing Aides (CNAs) received a performance review for 5 of 5 CNA files reviewed. This deficient practice was evidenced by the following: On 8/18/25 at 11:53 AM, the surveyor requested from the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) the annual education, competencies and performance reviews for five randomly selected CNAs. The facility provided a copy for each of the five CNAs which contained Nursing Assistant Clinical Skills Checklist and Competency forms and in-service education sign in sheets for education topics. The facility did	F0730	Element I All 5 CNAs without documented annual performance reviews were immediately completed by 08/25/25. Documentation was filed in their employee records. Element II All residents that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III Human resources in-serviced all department heads on the policy for mandatory yearly performance evaluation to avoid non compliance. Human resources will provide the Director of Nursing or Designee with a monthly list of the current licensing staff due for the annual evaluations. Human Resources will complete a monthly audit X 6 months review of the staff evaluation completed to maintain compliance with state regulations. Element IV	09/05/2025

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F0730 SS = E	Continued from page 39 not provide performance reviews for the five CNAs. On 8/19/25 at 1:59 PM, the surveyor asked the U.S. FOIA if the CNA performance evaluations were available. The U.S. FOIA stated that she could not locate them and if they were not with the Human Resources Department, they may not be in the building. On 8/19/25 2:15 PM, the survey team met with the U.S. FOIA and U.S. FOIA (b for concerns. The surveyor notified the U.S. FOIA and U.S. FOIA (b of the concern with the 5 out of 5 requested performance reviews for CNAs that were not available. The U.S. FOIA stated they did not have them. The surveyor requested any policies related to employee performance reviews. On 8/21/25 at11:56 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA and U.S. FOIA (b) (6) for responses to concerns. The U.S. FOIA stated that moving forward, performance reviews were to be included in the employee files and kept on site in the U.S. FOIA (b office. The facility did not provide any further pertinent information. N.J.A.C. 8:39-43.17 (b)	F0730	Continued from page 39 An audit of all CNA files was conducted to identify any other missing evaluations. Any outstanding reviews will be completed; monthly audits will be conducted x6 months and monitored by the administrator. Finding will be addressed during monthly Quality Assurance and Performance improvement meetings.	
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F0755	Element I Resident #7 was assessed by the Director of Nursing with NJ Ex Order 26.4(b)(1) observed. Nurse #1 was educated on the facilities policy on medication administrations with notation to sign narcotics upon removing from the package. Element II All residents that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III License staff were re-educated by the Director of Nursing on 08/22/2025 on the facilities policies and protocols for Medication Administration.	09/05/2025

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F0755 SS = D	Continued from page 40 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interview, and review of facility documents, it was determined that the facility failed to a.) provide pharmaceutical services in accordance with professional standards to ensure accurate accountability of NJ Ex Order 26.4(b)(1), have sufficient secure procedures in place to prevent diversion of NJ Ex Order 26.4(b)(1) for 1 of 4 residents observed during the medication administration observation and b.) ensure an accurate ordering and receiving of NJ Ex Order 26 medications specifically failing to complete the required U.S Official Order Forms NJ Ex Order 26.4(b)(1) forms) with sufficient detail to enable accurate reconciliation for 2 of 2 executed forms reviewed and the unexecuted NJ Ex Order 26.4(forms were signed by the U.S. FOIA (b) (6) prior to being filled out for 4 of 4 unexecuted forms reviewed. The deficient practice was evidenced by the following: Reference: Title 21 Chapter II Part 1305 Subpart B § 1305.13 Procedure for filling DEA Forms 222 (e) The purchaser must record on its copy of the DEA Form 222 the number of commercial or bulk containers furnished on each item and the dates on which the containers are received by the purchaser. Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing	F0755	Continued from page 40 Weekly medication pass observation will be done for 2 nurses by the Director of Nursing weekly for 4 weeks, then bi-weekly for 2 months, then monthly for 3 months to ensure adherence to protocol and standard nursing practices. Element IV Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance improvement meeting.	

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F0755 SS = D	Continued from page 41 medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1.On 8/18/25 at 8:36 AM, Surveyor #1 (S#1) began the Medication Administration Observation. S#1 observed the U.S. FOIA (b) (6)) assigned to the medication (med) cart on the West Unit prepare to administer due medications (meds) for Resident #7. S#1 observed the U.S. FOI remove two meds from the locked drawer containing NJ Ex Order 26.4(b)(1)). The U.S. FOI removed and administered NJ Ex Order 26.4(b) (a NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(NJ Ex Order 26.4(b)(1) the U.S. FOI return to the med cart and electronically sign the electronic med administration record (eMAR). S#1 did not observe the U.S. FOI sign the NJ Ex Order 26.4(b)(1) sheet (a log that tracks the number of a particular NJ Ex Or when removed for administration) for either med before or after they were administered. S#1 observed the U.S. FOI move on to the next resident for med administration. S#1 asked the U.S. FOI to see the NJ Ex Or Accountability sheet for Resident #7's NJ Ex Order 26.4(b)(and NJ Ex Order 26.4(b)(1 The sheets did not reflect that the U.S. FOI documented the removal of either dose. S#1 asked the U.S. FOI what the usual practice was when NJ Ex Or meds are removed for administration, and the U.S. FOI stated that it should be signed out when removed from the package and before giving to the resident. S#1 completed the med administration observation. S#1 reviewed the electronic medical record (EMR) for Resident #7 which revealed the following: A review of the admission record (AR, and admission summary), reflected that the resident had diagnoses that included but were not limited to NJ Ex Order 26.4(b) and	F0755		

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F0755 SS = D	Continued from page 42 NJ Ex Order 26.4(b)(1)). A review of the resident's Minimum Data Set (MDS), an assessment tool, with an assessment reference date of (ARD) NJ Ex Order , reflected a Brief Interview Mental Status (BIMS) score of NJ E out of 15, which indicates NJ Ex Order A review of an Order Summary Report (OSR), reflected that the resident had a current active physician's order (PO) for NJ Ex Order 26.4(b)(1) tablet (tab) and NJ Ex Order 26.4(b)(1) On 8/19/25 at 2:15 PM, the survey team met with the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)) to discuss the above concerns. S#1 notified the U.S. FOIA of the results of the med-pass observation as well as the concerns with signing the NJ Ex Order 26.4(b)(1) sheet. On 8/20/25 at 9:39 AM, S#1 interviewed the facility U.S. FOIA (b) (6)) by telephone. S#1 asked the U.S. F how the staff was expected to document the use of NJ Ex Ord The U.S. F stated that the nurse should sign the NJ Ex Or Accountability sheet immediately after removing the dose. A review of the undated facility's "Medication Administration Policy", revealed that the policy did not reflect any information related to NJ Ex Or or when to sign for NJ Ex Ord The facility did not provide any further pertinent information. 2.On 8/18/25 at 9:58 AM, the U.S. FOIA provided S#2 a copy of two executed NJ Ex Order 26.4(b forms and stated that there were only two NJ Ex Order 26.4(forms for the last year. She added that she did not order a lot of NJ Ex Order 26.4(b A review of the executed NJ Ex O forms included the following: Order Form: NJ Ex Order 26.4(b)(1) , dated NJ Ex Order 26.4(revealed no quantity of packages received and no date received of the two meds ordered, which was to be filled in by the purchaser. Order Form: NJ Ex Order 26.4(b)(1) , dated NJ Ex Order 26 , revealed no quantity of packages received and no date received of the three meds ordered, which was to be filled in by the purchaser.	F0755		

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F0755 SS = D	Continued from page 43 The facility did not record the number of packages of controlled substances received or the date each med was received as indicated on the instructions for filling out the NJ Ex Order 26.4(form. On 8/18/25 at 10:14 AM, S#2 asked the U.S. FOIA the process for the NJ Ex Order 26.4(forms. The U.S. FOIA stated that she would fill out the NJ Ex Order 26.4(form with the NJ Ex Order 26 med that was needed to order and then have the U.S. FOIA (b) (6)) sign the NJ Ex Order 26.4(form. She then would fax the NJ Ex Or form to the pharmacy before mailing it. The pharmacy would then process the order and send the meds. The nurse that received the meds would sign the requisition/declining sheet (not the NJ Ex Order 26.4(form) and that requisition/declining sheet was stored with the meds in the back up box. The surveyor asked the U.S. FOIA if the NJ Ex Order 26.4(form was filled out when the meds were received. The U.S. FOIA stated that she did not usually fill out the received part on the NJ Ex Order 26.4(form. On 8/18/25 at 10:26 AM, S#2 requested from the U.S. FOIA to view the unexecuted NJ Ex Order 26.4(forms that the facility had. The U.S. FOIA showed the surveyor four unexecuted NJ Ex Or forms which revealed the following: Order Form: # NJ Ex Order 26.4(b)(1 had the U.S. FOIA (b) (6)) signature and the rest of the form was blank. Order Form: # NJ Ex Order 26.4(b)(1 had the U.S. FOIA signature and the rest of the form was blank. Order Form: # NJ Ex Order 26.4(b)(1 had the U.S. FOIA signature and the rest of the form was blank. Order Form: # NJ Ex Order 26.4(b)(1 had the U.S. FOIA signature and the rest of the form was blank. The U.S. FOIA confirmed that the four unexecuted NJ Ex Order 26.4(forms were signed by the U.S. F and that they were not filled out with any med orders. On 8/18/25 at 10:32 AM, S#2 asked the U.S. FOIA if the blank NJ Ex Order 26.4(forms should be signed by the U.S. F prior to being filled out with a med order. The U.S. FOIA stated that the U.S. F was supposed to sign the NJ Ex Order 26.4(forms after the form was filled out with the order. She added that she did not realize they were signed before they were filled out. On 8/19/25 at 2:18 PM, S#2 notified the U.S. FOIA (and the U.S. FOIA the concern that the executed NJ Ex Order 26.4(forms were not completed properly when the controlled meds were received and that the unexecuted NJ Ex Order 26.4(forms that were blank (did not contain med order) were signed by	F0755		

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(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
F0755 SS = D	Continued from page 44 the U.S. FO On 8/20/25 at 9:42 AM, S#2 interviewed the U.S. F via telephone, regarding the process for NJ Ex Order 26.4(forms. The U.S. F stated that her process was to check the binder that contained the forms. The U.S. F stated that the U.S. FOIA had told her that the binder was not ready so she could not check the facility's binder. The U.S. F stated that she gave the previous U.S. FOIA a checklist which included to make sure there were no pre signed forms. The U.S. F stated that when the med was received the form should be filled out with how many received and attach the receipt. The previous U.S. FOIA had no experience and asked the U.S. FOIA to come back. The surveyor notified the U.S. F about the concerns with the NJ Ex Order 26.4(forms. The U.S. F stated that unfortunately she was not able to check the NJ Ex Order 26.4(forms. On 8/20/25 at 1:07 PM, in the presence of the U.S. FOIA (b) the U.S. FOIA stated that she had asked the U.S. FO to sign the NJ Ex Or form because she was going to place an order and he was going on vacation. She added that he signed the rest of the NJ Ex Order 26.4(forms. The U.S. FOIA (and U.S. FOIA did not provide any additional information. A review of the facility's "6.0 Controlled Dangerous Substance Inventory for Back Up Box and Emergency Kits Policy" with a revised date of September 2020, included the following: Policy …All CDS are dispensed and handled in accordance with state and federal regulations. Procedure A. CDS Inventory in Back Up Supply-Schedule II CDS (e.g. Demerol, Morphine, Percocet) 1. A DEA Form 222 must be completed to obtain the par level quantity of Scheule II CDS in back up supply. Upon signature of the Medical Director or his/her designee, the two copies are sent to the pharmacist in charge at …Pharmacy…. A review of the checklist titled "BACK-UP CONTROLLED SUBSTANCE CHECKLIST" that was provided by the CP included the following: DEA Form 222: When meds arrive from pharmacy, the date	F0755		

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F0755 SS = D	Continued from page 45 received and number of packages received is filled out (part 5)… Do not have any pre-signed 222 forms by medical director (use immediately or void & file in order) N.J.A.C. 8:39-29.4(l), 29.7(c)	F0755		
F0761 SS = D	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 be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store [redacted] and [redacted] according to clinical standards of practice. This deficient practice was identified in 1 of 4 Resident Room (Resident Room #[redacted] observed during tour of the facility. This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45,	F0761	Element I Resident from room #7 was reassessed with [redacted] noted. A full house audit was completed of all the residents' rooms with permission to monitor for any medication not properly stored. None noted. Element II All residents that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III Weekly audits of 5 rooms at random will be done weekly for 4 weeks, then monthly for 2 months thereafter to ensure proper storage of personal items is being done. Staff education was conducted on 08/21/2025 by the Director of Nursing on Label/Storing Drugs. Element IV Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance improvement meetings Director of Nursing or Designee. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting by the Director of Nursing or Designee.	09/05/2025

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F0761 SS = D	Continued from page 46 Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 8/18/25 at 10:38 AM, the surveyor with the U.S. FOIA (b) (6)) toured the NJ Ex Ord unit and observed Resident Room #[redacted] (RR#[redacted] behind the window curtain two containers of NJ Ex Order 26.4(b)(1) and container of NJ Ex Order 26.4(b)(1) with resident's name on it. The U.S. F had no answer as to why the NJ Ex Order 2 and NJ Ex Order 26.4(b)(1) was by the window. On 8/18/25 at 10:50 AM, the U.S. F called the assigned nurse, and it was the U.S. FOIA (b) (6)) who came inside RR#7. The U.S. FOIA (b) stated that the NJ Ex Order 26.4(b) should be stored inside the nurse's treatment cart. The U.S. FOIA (b) (also stated that it was the nurse who administer the NJ Ex O , and both the residents inside the room were NJ Ex Order 26.4(b)(1). On that same date and time, the surveyor asked why it was important that the containers of NJ Ex Order 2 and NJ Ex O should be stored properly. The U.S. FOIA (b) (responded in the presence of the U.S. F that it should not be stored inside residents' room for safety. She further stated that it was "probably" the Resident Representative who brought them. A review of the resident who had their name on NJ Ex O container revealed that the resident's order for NJ Ex Order 26.4(b) was discontinued on NJ Ex Order 26.4(On 8/19/25 at 2:15 PM, the survey team met with the U.S. FOIA (b) (6)), the U.S. FOIA (b) (6)), and the surveyor notified them of the above concerns. The U.S. FOIA stated that it was expected that the NJ Ex Order 26.4(b) be kept in the treatment cart and the NJ Ex Order 2 stored in their (resident) respective drawers. She further stated that the NJ Ex Order 2 could cause harm to any resident who can grabbed them so they should be stored properly.	F0761		

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F0761 SS = D	Continued from page 47 A review of the facility's "Storage of Medications Policy" that was provided by the U.S. FOIA with a revised date of 10/24, revealed that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner…The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner…The facility should not use discontinued, outdated, or deteriorated drugs or biologicals…Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications…Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use, and shall be stored separately from regular medications… NJAC 8:39-29.4(d)(g)(h)	F0761		
F0868 SS = E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate	F0868	Element I The Quality Assurance and Performance Improvement Committee was reconvened on 9/9/2025 to review the citation and initiate corrective planning. The U.S. FOIA (b) (6) was trained on the CMS regulation for Quality Assurance and Performance Improvement Committee to ensure each meeting will consist of the following representatives: Administrator, Director of Nursing, Assistant Director Of Nursing, Social Service Director, Director of Rehab Services, Director of Food Service, Activities Director, Medical Director, Human Resources, Director of Maintenance and the Infection Preventionist on 08/22/2025. Element II All residents that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III A quarterly audit of Quality Assurance and Performance Improvement meeting minutes, documentation, and	09/09/2025

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F0868 SS = E	Continued from page 48 and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to assure that the required staff attended the quarterly Quality Assurance (QA) meetings for 4 of 6 (U.S. FOIA (b) (6)) and 2 of 6 (U.S. FOIA (b) (6)) quarterly QA meetings according to the regulation and facility's practice. This deficient practice was evidenced by the following: On 8/18/25 at 1:56 PM, Surveyor #1 (S#1) reviewed the provided Quality Assurance Performance Improvement (QAPI) binder and revealed: On 3/28/24 QAPI meeting, the facility management signed the attendance sheet that included the U.S. FOIA (b) (6), Licensed Nursing Home Administrator #1 (LNHA#1), Director of Nursing #1 (DON#1), and Infection Preventionist #1 (IP#1). On 6/24/24 QAPI meeting, the U.S. FO LNHA#1 and IP#2 signed the attendance sheet. The U.S. FOIA did not sign and there was no report from the U.S. FOIA For NJ Exec Order 26.4b1 QAPI meeting, dated NJ Exec Order 2, LNHA#1, DON#1, and IP#2 signed the attendance sheet. The U.S. FO did not sign. For NJ Exec Order 26.4b1) QAPI meeting, dated NJ Exec Order 26 LNHA#1, DON#1, and IP#2 signed the attendance sheet. The U.S. FO did not sign. For NJ Exec Order 26.4b1 QAPI meeting, dated NJ Exec Order, LNHA#1 and DON#2 (also known as IP#2 who had a personnel action form changed position to U.S. FOIA signed the attendance sheet. The U.S. and the U.S. FO did not sign and there was no report from the U.S.	F0868	Continued from page 48 committee attendance will be conducted by the administrator or designee for 6 months. Element IV Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting.	

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F0868 SS = E	Continued from page 49 For Quarterly NJ Exec Order 26.4b1) meeting, dated NJ Exec Order, LNHA#1 and DON#2 signed the attendance sheet. The U.S. FO and U.S. did not sign and there was no report from the U.S. On 8/19/25 at 9:00 AM, IP#3 confirmed that she attended the QAPI meeting on NJ Exec Order, and reported for QAPI. She also stated that she did not attend the NJ Exec Order 2 QAPI. On 8/19/25 at 2:15 PM, the survey team met with LNHA#2 and DON#1, and S#1 notified them of the above concerns that the U.S. FO and U.S. did not attend the quarterly meeting routinely. S#1 notified LNHA#2 and DON#1 that the U.S. FO was called and did not return the call for an interview. At that same time, both LNHA#2 and DON#1 stated that the QAPI meeting schedule was announced in morning meeting. S#1 asked if the U.S. FO attends the morning meeting and the U.S. FOIA stated no, it was being relayed verbally when the U.S. FO was in the facility. On 8/20/25 at 8:25 AM, DON#1 provided an employee timeline from NJ Exec Order 26.4b1 to present for the following positions: DON: DON#1 was the DON from NJ Ex Order 26.4(b)(1) to NJ Ex Order DON#2 was the DON from NJ Ex Order to NJ Ex Order DON#1 was the DON from NJ Ex Order to present IP: IP#1 was the IP from NJ Ex Order 26.4(b)(1) to NJ Ex Order IP#2 was the IP from NJ Ex Order to NJ Ex Order IP#1 was the interim IP from NJ Ex Order to NJ Ex Order IP#3 was the IP from NJ Ex Order to present On 8/20/25 at 1:06 PM, the survey team met with LNHA#2 and DON#1. S#1 asked LNHA#2 and DON#1 if there was a response with regard to surveyor's concern with QAPI attendance of the U.S. FO and U.S. and the U.S. FOIA stated no response. On 8/21/25 11:55 AM, the survey team met with the U.S. FOIA (b) (6)), LNHA#2, and DON#1. S#2 asked if any additional responses and if the survey team could proceed with decision making. DON#1, LNHA#2, and U.S. FOIA (b) confirmed they had no additional responses, and the team could proceed with decision making.	F0868		

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F0868 SS = E	Continued from page 50 A review of the facility's "Quality Assurance Performance Improvement Plan" that was provided by the U.S. FOIA (b) (6) (previously LNHA#1), dated 6/2024, revealed that the facility's purpose is to provide excellent quality resident care and services…The QAPI Committee will consist of the following representatives: Administrator, DON, Assistant DON, Social Service Director, Director of Rehab Services, Director of Food Service, Activities Director, Medical Director, Human Resources Director, Director of Support Services, Director of Maintenance and at least two non-licensed staff people on a rotating basis/Community Representative… On 8/21/25 at 12:39 PM, DON#1 stated that the facility did not have [redacted] job description. S#2 asked if there was an agreement the [redacted] signed regarding their job description. DON#1 stated that she would check and ask other management. N.J.A.C. 8:39-33.1(a)(b)	F0868		
F0880 SS = E	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, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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:	F0880	Element I Resident #39 and #31 were reassessed with NJ Ex Order 26.4(b)(1) [redacted] noted due to the deficient practice. U.S. FOIA (b) (6) was retrained on outbreak response procedures, including testing protocol, documentation, line listing and communication protocols on 08/21/2025. Element II The residents who may have been exposed to a covid positive resident that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes was noted. Element III Licensed Staff was retrained by the Director of Nursing on outbreak response procedures, including testing protocol, documentation, line listing, and communication protocols on 08/21/2025. Audits of testing logs and outbreak response	09/05/2025

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F0880 SS = E	Continued from page 51 (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. §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 interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to follow	F0880	Continued from page 51 documentation will be conducted by the Infection Preventionist weekly until the Covid-19 Outbreak has been cleared by the Department of Health. Element IV Compliance with outbreak testing will be reviewed monthly during Quality Assurance and Performance Improvement meetings. Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting by the Director of Nursing.	

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F0880 SS = E	Continued from page 52 appropriate [NJ Ex Order 2] testing according to standards of clinical practice, facility's policy and procedure, and Centers for Disease Control and Prevention (CDC) guidelines. This deficient practice was identified for 10 of 16 facility staff (6 Certified Nursing Aides, 1 Registered Nurse, and 3 Licensed Practical Nurse) reviewed for [NJ Ex Order 26.4(b)] testing. This deficient practice was evidenced by the following: According to the CDC guidelines, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, March 18, 2024,…For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period…For this guidance it is defined as: a) being within 6 feet of a person with confirmed SARS-CoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation. Determining the time period when the patient, visitor, or HCP (Health Care Personnel) with confirmed SARS-CoV-2 infection could have been infectious: For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions. For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious. If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing. On 8/14/25 at 8:50 AM, the [U.S. FOIA (b) (6)]	F0880		

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F0880 SS = E	Continued from page 53 informed the survey team that the facility was in an NJ Ex Order 26.4 for NJ Ex Order 26.4(b) and there were two residents who NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b) who were in West unit of the facility. On 8/14/25 at 10:03 AM, Surveyor #1 (S#1) met with the U.S. FOIA (b) (6)) and U.S. FOIA during entrance conference, and S#1 asked them for the facility's NJ Ex Order 26.4(b)(testing and line listing. On 8/18/25 at 12:50 PM, S#1 reviewed the line listing that was provided by the U.S. FOIA (b) (6)), revealed: -Resident #39=NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b) on NJ Ex Order -Resident #31=NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b) or NJ Ex Order 2 On 8/19/25 at 9:00 AM, the U.S. FOIA (b) (6) provided a copy of the facility's contact tracing that included list of staff who were tested for NJ Ex Order 26.4(b) , and revealed: -On NJ Ex Order 26.4(b)(1) case, there were two Certified Nursing Aides (CNAs) and two nurse that were tested for NJ Ex Order 26.4(b) . The results were NJ Ex Order 26.4 for days 1, 3, and 5. -On NJ Ex Order 26.4(b)(1) case, there were one CNA and one nurse that were NJ Ex Order for NJ Ex Order 26.4(b) . The results were NJ Ex Order 26.4 for days 1, 3, and 5. -there were two residents and four therapists who were tested for both dates of NJ Ex Order 26.4(b) cases and results were NJ Ex Order 26.4(On that same date and time, S#1 asked the U.S. FOIA (b) (as to why there were only three CNAs and nurses that were tested for NJ Ex Order 26.4(b) for days 1, 3, and 5. S#1 also asked what the facility's practice and policy with regard to NJ Ex Order 26.4(b) was testing, and the U.S. FOIA (b) had no response. On 8/19/25 at 9:59 AM, S#1 interviewed the U.S. FOIA in the presence of the U.S. FOIA (b) The U.S. FOIA informed the survey team that as facility's practice, the NJ Ex Order 26.4(b)(1) resident and roommate should be tested for NJ Ex Order 26.4(b)(on days 1, 3, and 5. She further stated that all staff who	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315525	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD , NORTH BERGEN, New Jersey, 07047

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F0880 SS = E	Continued from page 54 had contacted with the resident should be tested for NJ Ex Order 26.4(b) on days 1, 3, and 5, and “usually” those staff who worked within 24 hours or three shifts. S#1 notified the U.S. FOIA and U.S. FOIA of the above findings and concerns that there were two CNAs and one nurse each identified NJ Ex Order 26.4(b)(1) dates that were tested for NJ Ex Order 26.4(b). . On 8/20/25 at 11:43 AM, the U.S. FOIA provided a copy of the CNA Assignment for NJ Ex Or side and revealed the following: NJ Ex Order 2 7:00 AM to 3:00 PM (7-3 shift): Assignment 2 CNA#1 and Registered Nurse #1 (RN#1) NJ Ex Order 2 3:00 PM to 11:00 PM (3-11 shift): Assignment 3 CNA#2 and LPN#1 NJ Ex Order 2 11:00 PM to 7:00 AM (11-7 shift): Assignment 2 CNA#3, LPN#1, and LPN#2 NJ Ex Order 2 7-3 shift: Assignment 2 CNA#4 and LPN#3 NJ Ex Order 2 3-11 shift: Assignment 2 CNA#5 and LPN#3 NJ Ex Order 2 11-7 shift: Assignment 2 CNA#6, RN#1, and LPN#4 NJ Ex Order 2 7-3 shift: Assignment 3 CNA#7 and LPN#5 NJ Ex Order 2 3-11 shift: Assignment 3 CNA#6 and LPN#5 NJ Ex Order 2 11-7 shift: Assignment 2 CNA#6 and RN#2 NJ Ex Order 2 7-3 shift: Assignment 2 CNA#8 and LPN#5 NJ Ex Order 2 3-11 shift: Assignment 3 CNA#5 and LPN#5 NJ Ex Order 2 11-7 shift: Assignment 2 CNA#3 and RN#2 Further review of the above CNA assignments (that included nurses) and NJ Ex Order 26.4(b)(1) revealed that RN#1, LPN#3, LPN#5, CNA#2, CNA#6, and CNA#9 (who was not in Residents #31 and #39’s CNA assignment) were the facility staff that were tested for NJ Ex Order 26.4(b)(on days 1, 3, and 5. On 8/20/25 at 1:06 PM, the survey team met with the U.S. FOIA (and U.S. FOIA S#1 asked the U.S. FOIA (and the U.S. FOIA if they had response for the above concerns about staff NJ Ex Order 26.4(b) testing, the U.S. FOIA (and U.S. FOIA had no response.	F0880		

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F0880 SS = E	Continued from page 55 A review of the facility's "COVID-19 Testing Policy" that was provided by the U.S. FOIA (b), revealed that the facility will implement testing of facility residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19. Definitions: "close contact" refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24 hour period…"Facility Staff" includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions… On 8/21/25 at 1:18 PM, the survey team met with the U.S. FOIA (b) U.S. FOIA (U.S. FOIA (b) (6), and U.S. FOIA (b) (6). S#2 asked if there were any additional information and the U.S. FOIA (did not provided additional information. NJAC 8:39-11.2(b), 19.4(a)(2),e	F0880		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and	F0883	Element I Resident #5, #7, # 52, and #62, were reassessed with NJ Ex [redacted] noted due to the deficient practice. The U.S. FOIA (b) (6) were re-educated on the facility policy for Influenza and Pneumococcal Immunization for residents that reside in the facility. Current residents were reviewed for NJ Ex Order 26.4(b)(1) status on 09/12/2025. Residents that consented and were eligible received the NJ Ex Order 26.4(b)(1) Proof of administration was recorded in the residents' electronic medical records. Education was provided to residents for availability of the flu vaccine and the Pneumococcal to maintain compliance with the state regulations during the Influenza Season. Element II All residents that reside in the facility have the potential to be affected by the deficient practice.	09/12/2025

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F0883 SS = E	Continued from page 56 (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that the facility failed to offer and administer resident a NJ Ex Order 26.4(b)(1). This deficient practice was identified for 4 of 5 residents (Residents #5, #7, #52, and #62) reviewed for NJ Ex Order 26.4(b)(1) This deficient practice was evidenced by the following: 1.On 8/19/2025 at 12:00 PM, Surveyor #1 (S#1) reviewed Resident #5's hybrid medical record. A review of Resident #5's Admission Record or face sheet (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted]	F0883	Continued from page 56 Element III Staff training was provided by the Director of Nursing on the facility protocol for Influenza and Pneumovax vaccines were conducted. Residents upon admission will be assessed for eligibility to receive the Pneumovax, and when indicated, will be offered the vaccination within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. Each resident will be offered an influenza immunization from October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time. Audits will be conducted by the Director of Nursing or the Infection Prevention nurse weekly for all new admissions vaccination records weekly for 4 weeks, then bi-weekly for 2 months, and then monthly for 3 months. Element IV Results of the audit will be presented to the Quality Assessment and Assurance Committee by the Director of Nursing or the Infection Prevention nurse during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting. Results of the audit will be presented to the Quality Assessment and Assurance Committee meeting during monthly Quality Assurance and Performance Improvement meetings. Identified negative findings will be immediately addressed and trends will be reported at the Quality Assurance and Performance Improvement meeting	

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F0883 SS = E	Continued from page 57 NJ Ex Order 26.4(b)(1)), NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)). A review of Resident #5's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of NJ Ex Order 2, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of N out of 15, which indicated that Resident #5's NJ Exec Order 26 was NJ Ex Order 26.4(b)(1). Further review indicated that the NJ Ex Order 26.4(b)(1) was offered and NJ Exec Order 26 A review of the NJ Ex Order 26.4(b)(1) section in the electronic medical record (EMR) revealed that the NJ Ex Order 26.4(b)(1) was offered, POA (power of attorney) NJ Ex Order 26.4 risks explained, NJ Exec Orde form obtained as verbal from POA, dated NJ Ex Order 26. There was no documented evidence in the hybrid medical record that the NJ Ex Order 26.4(b)(1) was offered for the Resident's current admission to the facility in NJ Ex Order 26.4(b). On 8/19/25 at 11:50 AM, S#1 interviewed the U.S. FOIA (b) (6) regarding process for offering the NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) stated that she would look up the resident's NJ Ex Order 26 record and that it would be offered if eligible and would be documented in the NJ Ex Order 26.4(b)(1) section of the EMR. The U.S. FOIA (b) (6 stated that she was currently going through all the resident's and getting consents for the NJ Ex Order 26.4(and NJ Ex Order 26.4(b)(1). She further stated that she started last week and that for residents that had refused in the past she would ask again. S#1 asked when the NJ Ex Order 26.4(b)(1) should be offered and she stated that it should be offered upon admission. S#1 asked the U.S. FOIA (b) the status of Resident #5, and she stated that she called resident's representative #1 (RR#1) and waiting for them. She added that RR#1 did not answer and that she did not document the attempted phone call in the medical record. S#1 then asked the U.S. FOIA (b) about the MDS that had offered and declined and the refusal was dated NJ Ex Order 26. The U.S. FOIA (b) stated that she did not know why the U.S. FOIA (b) (6)) had put offered and declined. On 8/20/25 at 12:01 PM, S#1 interviewed the U.S. FOIA (b)	F0883		

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F0883 SS = E	Continued from page 58 regarding Resident #5's MDS and NJ Ex Order 26.4(b)(1). The U.S. FOIA (b) stated that she had looked in the NJ Ex Order 26.4(b)(1) section and saw the refused and coded as such. S#1 asked if she checked the date for the entry in the NJ Ex Order 26.4(b)(1) section to see if it was up to date. The U.S. FOIA (b) stated that she would have to check and get back to S#1. On 8/20/25 at 1:23 PM, S#1 notified the U.S. FOIA (b) (6)) and U.S. FOIA (b) (6) the concern that Resident #5 did not have the NJ Ex Order 26.4(b)(1) offered upon admission. On 8/21/25 at 12:01 PM, in the presence of the U.S. FOIA (b) the U.S. FOIA stated that Resident #5 had refused the NJ Ex Order 26 in Assisted Living but that was NJ Ex Order 26.4(b)(1). The U.S. FOIA stated that she in-serviced staff and will start a Quality Assurance Performance Improvement (QAPI). 2.A review of the AR of Resident #7 revealed that the resident was admitted to the facility with diagnoses which included but not limited to NJ Ex Order 26.4(b)(1); NJ Ex Order 26.4(b)(1)), NJ Ex Orde , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) , and NJ Ex Order 26.4(b)(1). A review of the cMDS with an ARD of NJ Ex Order 26, reflected a BIMS score of NJ E out of 15, indicating NJ Ex Ord The MDS also reflected the NJ Ex Order 26.4(b)(1) as offered and declined. A review of the NJ Ex Order 26.4(b)(1) record revealed that the NJ Ex Order 26.4(b)(1) status was pending NJ Ex Order 26.4(b)(1) consent confirmed by the U.S. FOIA (b) on NJ Ex Order. On 8/18/25 at 11:54 AM, Surveyor #2 (S#2) interviewed the U.S. FOIA (b) (6), who informed S#2 that the facility's process with regard to NJ Ex Order 26.4(b)(1) was to obtain the NJ Ex Order 26.4(b)(1) records of the resident via a we based NJ Ex Order 26 registry, ask the resident, and verify with resident's physician the history of the resident's NJ Ex Order 26.4(b)(1) She also stated that she also try to get the records from the hospital but the hospital did not call her back. The U.S. FOIA (b) (6) added that she did not document about that she contacted the hospital inquiring about resident's NJ Ex Order 26.4(b)(1) records. At that same time, the U.S. FOIA (b) informed S#2 that she provided a consent form but did not use a declination form, and stated, "I usually" enter the information in	F0883		

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F0883 SS = E	Continued from page 59 the EMR that it was refused and education was given. She confirmed that she obtained a consent for NJ Ex Order 26.4(b)(1) [redacted] or NJ Ex Order 2[redacted], and would administer it next month, and that she would place an order to the pharmacy. On 8/19/25 at 2:32 PM, S#2 notified the U.S. FOIA ([redacted] and the U.S. FOIA [redacted] of the above concern. On 8/20/25 at 10:12 AM, the U.S. FOIA (b) [redacted] stated that she reviewed the NJ Ex Order 26.4(b)(1) [redacted] detail in the EMR and that was how she coded the resident's MDS. She also stated that she did not write notes regarding the resident's NJ Ex Order 26.4(b)(1) [redacted] On 8/20/25 at 12:01 PM, the U.S. FOIA (b) [redacted] informed S#2 that she reviewed the EMR and that the resident's NJ Ex Order 26.4(b)(1) [redacted] record showed that the NJ Ex Order 26.4(b)(1) was pending, and that no other option in the MDS to code it that was why she coded the MDS offered and declined. On 8/20/25 at 1:07 PM, the survey team met with U.S. FOIA ([redacted] and U.S. FOIA [redacted] and the U.S. FOIA [redacted] stated, “If there was no information, it should be offered.” 3.On 8/18/25 12:03 PM, Surveyor #3 (S#3) reviewed the EMR of Resident #52 for NJ Ex Order 26.4(b)(1) [redacted] A review of the AR reflected that the resident was admitted to the facility and had diagnoses that included but were not limited to; NJ Ex Order 26.4(b)(1) [redacted]), NJ Ex Order 26.4(b)(1) [redacted]), and NJ Ex Order 26.4(b)(1) [redacted]). A review of the quarterly MDS (qMDS), with an ARD of NJ Ex Order 26 [redacted], reflected a BIMS score of NJ E [redacted] out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) [redacted]. The qMDS reflected that the resident's NJ Ex Order 26.4(b)(1) [redacted] was not up to date and was not offered. A review of the NJ Ex Order 26.4(b)(1) [redacted] listed in the EMR revealed there was no documentation regarding the resident's NJ Ex Order 26.4(b)(1) [redacted] status. A review of the resident’s personalized Care Plan (CP), reflected a refusal of NJ Ex Order 26.4(b) [redacted], and NJ Ex Order 26.4(b)(1) [redacted] dated NJ Ex Order 26 [redacted]. The CP did not reflect any information for NJ Ex Order 26.4(b)(1) [redacted] status. A review of the Order Summary Report, did not reflect any orders for administration of a NJ Ex Order 26.4(b)(1) [redacted]	F0883		

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F0883 SS = E	Continued from page 60 NJ Ex Order 26. On 8/18/25, S#3 reviewed the hard copy chart of Resident #52, which revealed there was no documentation of administration or declination for the NJ Ex Order 26.4(b)(1) On 8/20/25 at 12:55 PM, S#3 interviewed the U.S. FOIA (b) (regarding Resident #52's NJ Ex Order 26.4(b)(1) status and how it was documented. The NJ Ex Order 2 stated that the NJ Ex Order 26.4(b)(1) record of the resident should be documented in the EMR. She further stated that moving forward there would be a note added in the resident's progress notes (PN). On 8/20/25 at 1:06 PM, the survey team met with the U.S. FOIA and U.S. FOIA (b) and S#3 notified them of the above concerns. On 8/21/25 at 11:56 AM, the survey team met with the U.S. FOIA (b) U.S. FOIA and U.S. FOIA (b) (6)), and the U.S. FOIA stated that they would conduct staff in-service education and QAPI interventions moving forward for the offering and education of residents for the NJ Ex Order 26.4(b)(1). 4.On 8/18/25 at 11:20 AM, Surveyor #4 (S#4) reviewed the EMR of Resident #62 for NJ Ex Order 26.4(b)(1) A review of the AR reflected that Resident #62 had diagnoses that included but were not limited to; NJ Ex Order , NJ Ex Order 26.4(b)(1)), and NJ Ex Order 26.4(b)(1)). A review of the cMDS assessment, with an ARD of NJ Ex Order 26, reflected a BIMS score of NJ out of 15, which indicated the resident had NJ Ex Order 26.4(b)(1) Section NJ of the MDS indicated the resident's NJ Ex Order 26.4(b)(1) was not up to date and was not offered. Under NJ Ex Order 26.4(b)(1) listed in the EMR revealed there was no documentation regarding the resident's NJ Ex Order 26.4(b)(1) status. A review of the PN revealed there was no documentation regarding the resident's NJ Ex Order 26.4(b)(1) status. On 8/18/25 at 11:56 AM, S#4 reviewed the hard copy chart of Resident #62, which revealed there was no documentation of administration or declination for the NJ Ex Order 26.4(b)(1).	F0883		

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F0883 SS = E	Continued from page 61 On 8/18/25 at 11:59 AM, S#4 interviewed the U.S. FOIA (b) (6) regarding immunizations. The U.S. FOI stated the U.S. FOIA (b) (was responsible for assessing and following up on resident's NJ Ex Order 26.4(b)(1) On 8/19/25 at 10:51 AM, S#4 interviewed the U.S. FOIA (b) (, who stated she was responsible for assessing and reviewing the residents' NJ Ex Order 26.4(b)(1) The U.S. FOIA (b) explained she would review the state online database for resident's NJ Ex Order 26.4(b)(1 records and asked residents and/or Resident's Representative #2 (RR#2) about NJ Ex Order 26.4(b)(1 status upon admission. She further stated that NJ Ex Order 26.4 would be offered to residents if they wished to receive them. The U.S. FOIA (b) also stated that NJ Ex Order 26.4(b)(1) would be documented under the NJ Ex Order 26.4(b)(1) section of the EMR. At that same time, S#4 asked the U.S. FOIA (b) about Resident #62's NJ Ex Order 26.4(b)(1) documentation and history. The U.S. FOIA (b) stated Resident #62 was newly admitted to the facility in NJ Ex Order 26.4(b) , and that she had to speak with RR#2 to ask about the NJ Ex Order 26.4(b)(1) . The U.S. FOIA (b) stated that she did not discuss with the resident and/or RR#2 yet to offer the NJ Ex Order 26.4(b)(1). S#4 asked the U.S. FOIA (b) (if there was a reason why she had not followed up with RR#2, and she replied that she was following up on obtaining other residents' consents for NJ Ex Order 26.4(b)(1 and she did not get to Resident #62's yet. On 8/19/25 at 2:15 PM, S#4 notified the U.S. FOIA (and the U.S. FOIA about the concern that the resident was not assessed or offered a NJ Ex Order 26.4(b)(1). On 8/20/25 at 1:06 PM, the U.S. FOIA (and the U.S. FOIA met with the survey team. The U.S. FOIA stated that there was no additional information regarding Resident #62's NJ Ex Order 26.4(b)(1). A review of the undated facility's "Pneumococcal Vaccine Policy", revealed, all residents will be offered the Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections… Under Policy Interpretation and Implementation revealed:… 1. Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax, and when indicated, will be offered the vaccination within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated...	F0883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315525	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD , NORTH BERGEN, New Jersey, 07047

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F0883 SS = E	Continued from page 62 2. Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission… N.J.A.C. 8:39-19.4 (i)	F0883		
F0947 SS = E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that Certified Nurse Aides (CNA) received at least twelve hours of mandatory in-service training for 5 of 5 CNAs education reviewed. This deficient practice was evidenced by the following: On 8/18/25 at 11:53 AM, the surveyor requested, from the U.S. FOIA (b) (6) employee files consisting of but not limited to staffing, competencies, and educational in-services for five randomly selected CNAs. The U.S. FOIA stated that the U.S. FOIA (b) (6)) was responsible for all the staff education. On 8/19/25, the surveyor reviewed the facility provided	F0947	Element I Performance evaluation completed for all direct care employees on 09/12/2025 and will be ongoing yearly thereafter. Director of Nursing or designee will keep track of performance evaluation and binder will be kept in DON office. ' Mandatory in-service for residents' abuse prevention, dementia management training and residents' rights was provided to the nurse aides employed by the facility who performs direct care to the residents. On-going training in the mandatory 12 hours will be maintained yearly. Element II The residents that reside in the facility have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III On 8/27/2025 The Director of Nursing educated the nurse educator on the new implemented training calendar that ensures all CNAs receive a minimum of 12 hours in-service education annually. This will include mandatory topics such as Resident abuse prevention, dementia management training and resident rights training, facility Assessment, and QAPI (Quality Assurance Performance Improvement). The facility educator or designee will track monthly audits for completion and maintain records of the CNA mandatory 12-hour education records. Records to be kept in the Director of Nursing office. Human resources will provide the Director of Nursing or Designee with a monthly list of the current and newly licensing or certified staff with the date of hire to	09/12/2025

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F0947 SS = E	Continued from page 63 in-service education for five randomly selected CNAs, which revealed the following: Five of five Nursing Assistant Clinical Skills Checklist and Competency evaluations had no hours listed as education and did not include topics such as Abuse Prevention. Eight in-service education attendance sheets with dates including 1/28/25, 2/5/25, 3/3/25, 4/8/25, 5/13/25, 6/3/25, 8/1/25, and 8/4/25. Each sheet reflected a time of sixty minutes duration, but did not reflect any topic related to Abuse or Abuse Prevention, or Quality Improvement Performance Improvement (QAPI). The eight sheets provided reflected a total of eight hours education. On 8/19/25 at 1:38 PM, the surveyor interviewed the U.S. FOIA (b) about staff education. The U.S. FOIA (b) stated that staff education was on paper. The U.S. FOIA (b) further stated that they go to each shift and education was provided to the staff who were on the schedule, and she come in on the weekend to find other staff. The U.S. FOIA (b) added that they just use a general staff list and did not have a tracker or log. At that same time, The U.S. FOIA (b) stated that they believed it was annual by calendar and was not aware it was by hire date on how to monitor the CNAs mandatory in service. The surveyor asked for a policy for mandatory staff in-services. On 8/20/25 at1:06 PM, the survey team met with U.S. FOIA and U.S. FOIA (b) (6)), and the surveyor notified them of the above concern with the employee education files not having the required 12 hours and not having mandatory topic such as Abuse, Abuse Prevention, Facility Assessment, and QAPI (Quality Assurance Performance Improvement). The U.S. FOIA stated that they would provide further evidence for educational in-services with such topics as abuse with electronic records On 8/20/25 at 2:02 PM, the U.S. FOIA informed the surveyor there was no electronic education records for NJ Exec Of and stated that it was for NJ Exec C only. On 8/21/20 at 11:56 AM, the survey team met with the U.S. FOIA U.S. FOIA (and U.S. FOIA (b) (6)), and the U.S. FOIA stated that the staff in charge of education would be in-serviced, there would be a QAPI started to ensure the education was kept up to date, and the documents would be kept on site in the U.S. FOIA (office. The U.S. FOIA also stated that there were previous employees that were responsible for keeping the documents current.	F0947	Continued from page 63 track the employee 12- hour mandatory education hours. Element IV Monthly audits will be done by the Director of Nursing or designee of all staff performance evaluations and mandatory CNA in-services monthly X 4 weeks, then biweekly for 2 months then monthly x 3 months. Results of the audit will be presented to the Quality Assessment and Assurance Committee by the Director of Nursing during monthly Quality Assurance and Performance Improvement meetings.	

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F0947 SS = E	Continued from page 64 A review of the facility's "Prohibition of Resident Abuse and Neglect Policy", dated 7/18/22, reflected, under Training: 1. Employees will receive abuse prevention training at orientation and annually. The facility did not provide any further pertinent information. N.J.A.C. 8:39-43.17(b)	F0947		

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H0000	Initials Comments A Recertification Survey was conducted, and it was determined that the facility was not in compliance with the requirements under N.J.A.C. 8:43 E General Licensure Procedures And Standards Applicable To All Licensed Facilities.	H0000		09/05/2025
H3470	Other Rprtng Rqrmnts Unrltd to Pt Sfty Act CFR(s): 8:43E-10.11(c)(2) Examples of reportable events in the nature of physical plant and operational interruptions, include, but are not limited to, the following: Loss or significant reduction of water, electrical power, or any other essential utilities necessary to the operation of the facility. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on record review and interview on 8/15/25, in the presence of the Director of Facility Operations (DOFO) and Administrator, it was determined that the facility failed to notify the Department Of Health (DOH) of reportable events in the nature of physical plant and operational interruptions. This deficient practice had the potential to affect 55 residents, who currently live at the facility, and was evidenced by the following: A record review on 8/15/25, revealed that the generator test log indicated that there was a power outage on 8/6/25 from 9:10 AM until 7:55 PM, over 10 hours. In an interview at the time, the Administrator and DOFO were asked if notification of the power outage was given to the DOH. The DOFO and Administrator stated that they were unaware that they needed notify the DOH of the power outage because the emergency generator covers 100% of the long-term care unit and was working at the time. The facility's Administrator and DOFO were informed of the deficient practices at the Life Safety Code exit	H3470	Element I The Administrator notified the NJ DOH of the power outage on 09/10. The generator provided uninterrupted essential services to all residents, and the electric company completed the underground rewiring. The deficient practice was immediately corrected. Element II All residents had the potential to be affected during the outage. No adverse outcomes occurred because the emergency generator maintained full coverage of essential utilities and care services. Element III Administrator re-educated all department heads on mandatory DOH reporting of physical plant and operational interruptions. Element IV Audits will done by the administrator, maintenance director or designee monthly x6 months to monitor any electrical events. Upon loss of power Director of Maintenance or Director of Nursing will notify the Administrator to determine	09/10/2025

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

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H3470	Continued from page 1 conference on 8/15/25 at 1:00 PM. N.J.A.C 8:39-31.2(e) N.J.A.C 8:43 E- 10.11 (c) (2)	H3470	Continued from page 1 if reporting is necessary. Results of the audits will be reviewed and discussed during monthly Quality Assurance and performance improvement meetings.	
H5790	UNIVERSAL TRANSFER FORM:MANDATORY USE OF FORM CFR(s): 8:43E-13.4(d) A licensed healthcare facility or program shall retain a completed copy of the Universal Transfer Form sent with a patient when a patient is transferred as part of the patient's medical record. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview, review of the medical records, and other facility documentation, it was determined that the facility failed to maintain a copy of the New Jersey Universal Transfer Form (UTF) as part of the medical record for 1 of 1 resident reviewed for hospitalizations (Resident #57). This deficient practice was evidenced by the following: Reference: New Jersey Administrative Code 8:43 E General Licensure Procedures and Standards: Section 8:43E-13.4 - Mandatory use of Universal Transfer Form (a) A licensed healthcare facility or program shall use the UTF, HFEL-7, provided as N.J.A.C. 8:43E-13 Appendix, incorporated herein by reference, and available on the Department's website at http://web.doh.state.nj.us/apps2/forms/, in either paper or electronic version, whenever a patient is transferred to another licensed healthcare facility or program. 1. Emergency departments are exempt from mandatory use of the UTF, but shall follow hospital procedures regarding documentation. (b) A licensed healthcare facility or program shall complete all sections of the UTF, to the best of the licensed healthcare facility or program's ability. 1. The UTF is not complete if medication information is not attached. (c) A licensed healthcare facility or program shall send a completed, paper copy of the UTF with a patient	H5790	Element 1 Resident #57. was discharged from the facility and was no longer active during the time of the annual survey conducted by the Department of Health. A full house audit of resident's files of who was transferred to [N.J.Ex Order 26.4(b)(1)] within the last 30 days have been reviewed and were noted with a completed Universal Transfer Form. Element II All residents who were transferred to the hospital have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III On 08/22/2025, the licensed nurses were educated by the Director of Nursing on the regulations and the facilities procedures to provide a completed Universal Transfer Form at the time of the transfer. Element IV Audit of three hospital transfers will be conducted by the Social Worker weekly for 4 weeks, then bi-weekly for 2 months, then monthly for 3 months. The audits will be reviewed by the Social Worker and/or designee to ensure that all transfers out of the facility have a completed Universal Transfer Form. Results of the audit will be reviewed and discussed during Quality Assurance and Performance Improvement meetings monthly x 6 months.	09/05/2025

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H5790	Continued from page 2 when a patient is transferred. (d) A licensed healthcare facility or program shall retain a completed copy of the UTF sent with a patient when a patient is transferred as part of the patient's medical record. On 8/18/25 at 9:31 AM, the surveyor reviewed Resident #57's closed electronic medical record. A review of Resident #57's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ Ex Order 26.4(b)(1) ([redacted]), NJ Ex Order 26.4(b)(1) ([redacted]) and NJ Ex Order 26.4(b)(1) ([redacted]). A review of Resident #57's progress notes indicated the resident was transferred to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26.4 The resident did not return to the facility. A review of Resident #57's most recent Discharge Return Anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, reflected that the resident was transferred to NJ Ex [redacted] A review of Resident #57's electronic medical record section Misc (miscellaneous; contains paper documents that were uploaded to the electronic medical record) did not contain a copy of the UTF for NJ Ex Order 26. Further review revealed a UTF dated NJ Ex Order 2, from a previous hospitalization, that was uploaded into the electronic medical record. A review of Resident #57's paper medical record that was provided by the facility, did not contain a copy of the UTF for the resident's transfer to NJ Ex Order 26.4(b)(1) on NJ Ex Order 26. On 8/18/25 at 10:29 AM, the surveyor asked the Director of Nursing (DON) if the complete paper medical record was given for Resident #57. The DON stated that yes it was complete and that everything else should be uploaded in the electronic medical record. On 8/19/25 at 11:01 AM, the surveyor interviewed the NJ Ex Ord Unit Clerk (NJ Ex Order regarding uploading of documents. The NJ Ex Ord stated that she was not sure who uploaded.	H5790		

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H5790	Continued from page 3 On 8/19/25 at 11:24 AM, the surveyor interviewed the DON regarding uploading of documents. The DON stated that she or the Unit Clerk did. She added that anyone that had access to a scanner could also. On 8/19/25 at 2:21 PM, the surveyor asked the DON to review the facility provided paper chart and the DON confirmed that the UTF for 6/24/25 was not in the paper chart. The surveyor notified the License Nursing Home Administer (LNHA) and the DON the concern that there was not a copy of Resident #57's UTF. On 8/20/25 at 1:16 PM, the survey team met with the LNHA and DON for a response for the concern. The LNHA and DON did not have a response. The LNHA or DON did not provide any additional information. A review of the undated facility's "Charting/Documenting Policy" included the following: Transfer (Hospital, Another Facility) A Patient Transfer Form (NJ transfer) is to be completed at the time of transfer to the hospital or another facility. All sections of the transfer form must be completed… Copy of transfer sheet is left on resident's chart…	H5790		
S0000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 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.	S0000		09/05/2025
S1405	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(a) The facility shall require all new employees to complete a health history and to receive an examination performed by a physician or advanced practice nurse, or	S1405	Element I Licensed Staff physicals were reviewed for all new hires for the past 30 days, and physicals were completed. New physical form has been implemented to include RN to sign off if md unable to perform physical	09/05/2025

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S1405	Continued from page 4 New Jersey licensed physician assistant, within two weeks prior to the first day of employment or upon employment. If the new employee receives a nursing assessment by a registered professional nurse upon employment, the physician's or advanced practice nurse's examination may be deferred for up to 30 days from the first day of employment. The facility shall establish criteria for determining the completeness of physical examinations for employees. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility provided pertinent documentation, it was determined that the facility failed to ensure that newly hired employees had completed a health history and received an examination by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment for 4 of 10 employee files reviewed, (Staff Member (SM) #1, #3, #9, and #10). This deficient practice was evidenced by the following: On 8/18/25 at 11:53 AM, the surveyor requested from the Director of Nursing (DON) the medical files of 10 randomly selected new hire employees. A review of the 10 facility provided files requested included the following: SM #1, with a date of hire (doh) NJ Ex Order 26.4 had a physical done that was undated. SM #3, with a doh NJ Ex Order 26.4, had a physical dated NJ Ex Order 26.4. The physical was done after doh. SM #9, with a doh 5/6/24, had a physical dated NJ Ex Order 26.4 The physical was done after doh. SM #10, with a doh NJ Ex Order 26.4 had a physical dated NJ Ex Order 26.4 The physical was done after doh. On 8/20/25 at 12:57 PM, the surveyor interviewed the Infection Preventionist/Licensed Practical Nurse (IP/LPN). The surveyor asked who was currently responsible for documenting the physicals and who was responsible immediately prior to the IP/LPN hiring. The IP/LPN stated that the previous DON was responsible prior to her hiring and that she was responsible when she was hired. The surveyor asked the IP/LPN if they were aware of the physicals being late. The IP/LPN stated that they	S1405	Continued from page 4 prior to start date as per facility's policy. Element II The resident that reside in the facility who were assigned to the licensed staff, have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III The Director of Nursing in-serviced staff member in charge of employee health, about the facility policy and protocol regarding new hire physicals. A new checklist will be created for new hire files to ensure all required documentation, including TB screening results, is present and verified by the hiring manager and/or Infection Preventionist prior to the employee's first day of work. Element IV The Director of Nursing or a designee will perform a monthly audit of all new hire files for the next six months to ensure compliance with the new policy. The audit will verify that the required physical form is completed and documented as per the facility's policy. Findings will be addressed and discussed monthly during the Quality Assurance and Performance improvement meetings.	

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S1405	Continued from page 5 thought that they had thirty days to complete after hiring. On 8/20/25 at 1:06PM, the survey team met with DON and Licensed Nursing Home Administrator (LNHA), and the surveyor notified them that there were three employees with physicals done after the doh and one physical that was undated. On 8/21/25 at 11:56 AM, the survey team met with the LNHA, DON and Regional DON (RDON), and the LNHA stated that there were no policies on file for new hires, onboarding or physicals and that they just follow the state regulations. The DON stated that the facility would be changing the forms that were used for physicals to include a nursing assessment that would allow 30 days for the physician to complete the physical. The facility did not provide any further pertinent information	S1405		
S1410	Mandatory Infection Control and Sanitation CFR(s): 8:39-19.5(b)(1) (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure newly hired employees completed the required NJ Ex Order 26.4(b)(1) upon hire. The	S1410	Element I Employee files were reviewed for the past 6 months to identify any individuals who are missing a two-step (PPD) or a documented alternative screening. Element II The resident that reside in the facility who were assigned to the licensed staff, have the potential to be affected by this deficient practice. No adverse outcomes were noted. Element III Staff #1 and Staff #9 received the required TB screening immediately on 08/21/2025. All required documentation will be found in the employee's file. For any other employees identified in step 1, the same corrective action will be taken to ensure all required TB screening is completed and documented. A new checklist will be created for new hire files to	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030901	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD , NORTH BERGEN, New Jersey, 07047

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S1410	Continued from page 6 deficient practice was identified for 2 of 10 randomly selected new employees (Staff #1 and #9). This deficient practice was evidenced by the following: The surveyor reviewed 10 randomly selected newly hired employee files. A review of the NJ Ex Order 26.4(b)(1) upon hire for 2 of the 10 new employees revealed the following: Staff #1, the Director of Maintenance (DoM), hired on NJ Ex Order 26, had NJ Ex Order 26.4(b)(1) completed. The employee file revealed that an alternative NJ Ex Order 26.4(b)(1) was conducted which was a NJ Ex Order 26.4(b)(1)) with a date of service NJ Ex Order 26. The NJ Ex Or was conducted after the date of hire (doh). Staff #9, the facility Infection Preventionist/Licensed Practical Nurse (IP/LPN), hired on NJ Ex Order 2 and there was no evidence present in the file that a NJ Ex Or was completed. There was no NJ Ex Order 26.4(b)(1 result found in the employee's file. There was no additional documentation in the file to indicate any NJ Ex Order 26.4(or alternative NJ Ex was completed upon hire. On 8/20/25 at 12:57 PM, the surveyor interviewed the IP/LPN. The surveyor asked who was currently responsible for documenting the NJ Ex Or and who was responsible immediately prior to the IP/LPN hiring. The IP/LPN stated that the previous Director of Nursing (DON) was responsible prior to her hiring and that she was responsible after she was hired. The surveyor asked the IP/LPN if they were aware of no PPD being present for Staff #1. The IP/LPN stated that the staff member stated they had a previously NJ Ex Or due to receiving a "NJ Ex Order 26.4(b)(1) " in the past that can cause NJ Ex Order 26.4(b)(1) results, so a NJ Ex Or was done. The surveyor asked why the NJ Ex Or was after the doh. The IP/LPN stated that she lost track of time and ordered it late. On 8/20/25 at 1:06PM, the survey team met with DON and Licensed Nursing Home Administrator (LNHA), and the surveyor notified them that there were two employees with either missing or late NJ Ex Order 26.4(b)(1). The surveyor asked the DON if they were aware of the two employees, specifically Staff #9 not having any record of NJ Ex The DON stated they were not aware and could not explain why there was no NJ Ex Or in Staff #9s record.	S1410	Continued from page 6 ensure all required documentation, including TB screening results, is present and verified by the hiring manager and/or Infection Preventionist prior to the employee's first day of work. The Director of Nursing in-serviced staff member in charge of employee health, about the facility policy and protocol regarding new hire physicals. Element IV The DON or a designee will perform a monthly audit of all new hire files for the next 6 months to ensure compliance with the new policy. The audit will verify that all required TB screening is completed and documented. Any discrepancies found during the monthly audits will be immediately discussed and addressed during monthly Quality Assurance and Performance Improvement meetings.	

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S1410	Continued from page 7 On 8/21/25 at 11:56 AM, the survey team met with the LNHA, DON and Regional DON (RDON), and the LNHA stated that there were no policies on file NJ Ex Or or NJ Ex Order 26.4(b) and that they just follow the state regulations. The DON stated that the facility will be changing the forms that were used and now staff would not be allowed to start without the proper documentation being verified in the record. The LNHA did not provide any further pertinent information.	S1410		

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F0000	INITIAL COMMENTS An onsite revisit was conducted for the 8/21/2025 Recertification survey. The facility was found to be in substantial compliance with the implementation of their POC.	F0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

New Jersey State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 030901	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/24/2025

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H0000	Initials Comments An on-site revisit survey was conducted on 9/24/25 to verify the facility's Plan of Correction for the 8/21/25 Relicensure survey. The facility was found to be in compliance with the requirements under N.J.A.C. 8:43 E General Licensure Procedures and Standards Applicable to All Licensed Facilities.	H0000		
S0000	Initial Comments An onsite revisit was conducted for the 11/7/2025 State of New Jersey Re-Licensure survey. The facility was found to be in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities	S0000		

Office of Primary Care and Health Systems Management

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K0000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 08/14/2025 and 08/15/2025. Harbour View Senior Living was found to be in NON-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. Harbour View is a 10-story building, including the basement. Floor 1-basement: Kitchen, laundry, boiler rooms Floor 2- Lobby Floor 3- Skilled nursing floor. (LTC) Floor 4-10: Assisted Living. The facility is separated into 2 units, East-(26 beds) and West-(33 beds). The facility is equipped with a 150 KW diesel generator that powers 100% of the LTC floor, per the Maintenance Director. The sprinkler system is equipped with an electric fire pump. The occupied beds at the time of survey were 55 of 60.	K0000		09/05/2025
K0223 SS = F	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke	K0223	Element I The facility immediately corrected all deficiencies cited under Tag K0223 as follows: The South exit stairway 1 door was equipped with compliant fire-rated hardware and fully tested for proper operation. See exhibits labeled 1 and 1A. The smoke barrier door pair between the East and West units was adjusted and repaired so that the astragal strip no longer overlaps the hardware, allowing both doors to fully and simultaneously close into the frame. See exhibits labeled exhibit 2 The exit stairway enclosure 5 door was:	09/05/2025

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 reverse for further 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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K0223 SS = F	Continued from page 1 passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 08/14/2025 and 08/15/2025 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that doors in stairway enclosures, smoke barriers and hazardous areas were in accordance with NFPA 101:2012 Edition, Sections 19.2.2.2.7, 19.2.2.2.8, 19.3.7.(6)-(8) and 7.2.1.8.2. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 08/14/2025 from 11:07 AM to 12:47 AM revealed the following: The South exit stairway 1 door was not equipped with fire rated hardware.The smoke barrier doors between the east and west units did not close properly as the door equipped with an astragal strip was overlapping onto the other door's hardware. This condition prevented both doors from fully closing into the frame when tested by the U.S. FOIA (b).The exit stairway enclosure 5 door was equipped with a delayed egress locking arrangement. The delayed egress feature did not function when tested by the U.S. FOIA (b) Additionally, the door was not provided with fire rated hardware and the was a half inch space between the top of the door and the door frame.The North exit stairway 1 door was equipped with a delayed egress locking arrangement. The delayed egress feature did not function when tested by the U.S. FOIA (b) Additionally, the door was not provided with fire rated hardware.The laundry room door did not self-close and positive latch when tested by the U.S. FOIA (b).The stairway enclosure door in the kitchen did not self-close and positive latch when tested by the U.S. FOIA (b) In interviews at the time, the U.S. FOIA (b) confirmed the observations. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) were informed of the deficient practices at the Life Safety Code exit conference on 08/15/2025 at 1:00 PM.	K0223	Continued from page 1 Repaired so that the delayed-egress feature functions properly, see exhibits labeled 3a Equipped with appropriate fire-rated hardware, see exhibits labeled 3b The ½-inch top gap was corrected to meet NFPA 101 clearance requirements. see exhibits labeled 3c and 3c1 The North exit stairway 1 delayed-egress door was repaired and recalibrated to ensure proper delayed-egress function and equipped with compliant fire-rated hardware. See exhibit labeled exhibit 4 The laundry room door was repaired by adjusting the closure device and hinges to ensure it self-closes and positively latches when released. See exhibit labeled exhibit 5 The kitchen stairway enclosure door was repaired by adjusting hinges and closure device to ensure proper self-closing and positive latching. See exhibit labeled exhibit 6 Element II All residents had the potential to be affected should a self-closing or delayed egress door fail to operate properly during an emergency evacuation. No adverse outcomes were identified. Element Ill Administrator re-educated U.S. FOIA (b) (6) and maintenance staff on compliance of K0223. Preventive Maintenance Log updated to include monthly door testing and documentation of delayed-egress doors. The Administrator or designee will inspect delayed-egress and self-closing doors weekly for 3 weeks, then monthly x 5, then annually per regulation to ensure continued proper function. Element IV Inspection findings will be reviewed at monthly QAPI meetings for 6 months. Any issues will receive immediate correction.	

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K0223 SS = F	Continued from page 2 N.J.A.C 8:39 – 31.2 (e)	K0223		
K0281 SS = F	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 08/14/2025 and 08/15/2025 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that illumination of the means of egress was in accordance with NFPA 101:2012 Edition, Sections 19.2.8 and 7.8. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/14/2025 at 12:20 PM revealed that illumination of the means of egress was not provided outside of the building at neither the exit door nor to a public way when exiting the west side unit. In an interview at the time, the U.S. FOIA (b) [redacted] confirmed the observation. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) [redacted] were informed of the deficient practice at the Life Safety Code exit conference on 08/15/2025 at 1:00 PM. N.J.A.C 8:39 – 31.2 (e)	K0281	Element I Lighting was installed at the west side exit to provide proper illumination to a public way. Element II All residents had the potential to be affected in the event of evacuation. No harm was noted. Element Ill Administrator re-educated U.S. FOIA (b) (6) [redacted] and maintenance staff on compliance of K0281 requirements of egress lighting added to monthly environmental rounds. The Administrator or designee will audit exterior emergency egress lighting monthly for 6 months to ensure proper illumination. Element IV Audit results will be presented at monthly QAPI meetings for 6 months. Any deficiencies found will receive immediate corrective action.	09/05/2025
K0291 SS = F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1	K0291	Element I Non-functioning battery units were replaced. Annual 90-minute functional test was performed and documented. Element II All residents had the potential to be affected during power loss. No injuries occurred.	09/05/2025

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K0291 SS = F	Continued from page 3 This STANDARD is NOT MET as evidenced by: Based on record review, observations and interviews on 08/14/2025 and 08/15/2025 in the presence of the U.S. FOIA (b) (6)), it was determined that the facility failed to ensure that periodic testing of emergency lighting equipment was conducted in accordance with NFPA 101:2012 Edition, Section 7.9.3. This deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/14/2025 at 11:15 AM revealed that the emergency lighting on the east side of the facility was provided by battery powered emergency lighting equipment. When the light switch in the hallway was placed in the “OFF” position, 3 of 5 battery powered units did not automatically turn on and stay on. In an interview at the time, the U.S. FOIA (b) confirmed the observation, and the surveyor requested Inspection, Testing and Maintenance (ITM) of the battery powered emergency lighting equipment. A record review on 08/15/2025 revealed that battery powered emergency lighting equipment was inspected monthly but documentation of functional testing that was conducted annually for a minimum of 90 minutes could not be found. In an interview at the time, the U.S. FOIA (b) confirmed the record review. The facility’s U.S. FOIA (b) (6) and the U.S. FOIA (b) were informed of the deficient practice at the Life Safety Code exit conference on 08/15/2025 at 1:00 PM. N.J.A.C 8:39 – 31.1(c), 31.2 (e)	K0291	Continued from page 3 Element Ill Administrator re-educated U.S. FOIA (b) (6) and maintenance staff on compliance of K0291 requirements. A new Emergency Lighting Log was implemented, including monthly and annual testing. Administrator or designee will review logs monthly to ensure compliance and perform random testing for accuracy monthly for 3 months. Element IV Results discussed at monthly QAPI for 3 months. Any deficiencies found will receive immediate corrective action.	
K0324 SS = F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K0324	Element I Kitchen hood fire suppression system was inspected and serviced by ABC fire and safety on 01/02/25, and 07/07/25, to meet requirements of K0324. A copy of full inspection report has been uploaded into EPOC as supporting documentation. Element II	09/05/2025

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K0324 SS = F	Continued from page 4 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on record review and interview on 08/14/2025 and 08/15/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance (ITM) of the kitchen range-hood fire suppression system was conducted semi-annually in accordance with NFPA 96:2011 Edition, Section 11.2.1. This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 08/15/2025 revealed that the kitchen range-hood fire suppression system was only inspected once (06/14/24), in 2024. In an interview at the time, the U.S. FOIA (b) confirmed the record review. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b) were informed of the deficient practices at the Life Safety Code exit conference on 08/12/2025 at 1:00 PM. N.J.A.C 8:39-31.1(c), 31.2(e) NFPA 96	K0324	Continued from page 4 All residents and staff had the potential to be affected by insufficient kitchen hood suppression system in the event of a fire. No fire events occurred. Element Ill Administrator re-educated U.S. FOIA (b) (6), U.S. FOIA (b) (6), and maintenance staff on K0324 Semi-annual service contract established with certified vendors to ensure timely inspections and compliance. Administrator or designee will call fire suppression vendor 1 month prior to scheduled due visit and audit for timely completion of service. Element IV Maintenance service schedules will be reviewed monthly at QAPI to ensure proper scheduling and completion of scheduled hood inspections.	
K0351 SS = F	Sprinkler System - Installation CFR(s): NFPA 101	K0351	Element I Sprinkler system company was called immediately to schedule sprinkler installation and sprinklers were	09/28/2025

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K0351 SS = F	Continued from page 5 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 08/14/2025 and 08/15/2025 in the presence of the U.S. FOIA (b) (6) , it was determined that the facility failed to ensure that it was protected throughout by an approved automatic sprinkler system in accordance with NFPA 101:2012 Edition, Sections 19.3.5.(1)- (5), 9.7 and NFPA 13, Standard for the installation of Sprinkler Systems. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 08/14/2025 from 12:07 PM to 12:18 PM revealed that sprinkler protection was not provided in the dietary office in the west side nurses station and in the vestibule near the west side exit door. In interviews at the time, the U.S. FOIA (b confirmed the observations. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b were informed of the deficient practices at the Life Safety Code exit conference on 08/15/2025 at 1:00 PM. N.J.A.C 8:39 – 31.1(c), 31.2 (e)	K0351	Continued from page 5 installed. Element II All residents had the potential to be affected by inadequate sprinkler coverage. No incidents occurred. Element III Administrator re-educated U.S. FOIA (b) (6) and maintenance staff re-educated on compliance of K0351. The administrator or designee will perform quarterly sprinkler coverage for 6 months, then annually. Element IV Audit findings will be reported to QAPI monthly for 6 months. Any deficiencies found will receive immediate corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315525	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ANNEX2 B. WING	(X3) DATE SURVEY COMPLETED 08/21/2025

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HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD , NORTH BERGEN, New Jersey, 07047

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K0351 SS = F	Continued from page 6 NFPA 13	K0351		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on record review, observations and interviews on 08/14/2025 and 08/15/2025 in the presence of the U.S. FOIA (b) (6), it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance of the Sprinkler system was in accordance with NFPA 101:2012 Edition, Sections 9.7.5, 9.7.7, 9.7.8 and NFPA 25: 2011 Edition, Section 4.3, 4.4, 4.5 ,Chapters 5 and 8. This deficient practice had the potential to affect all residents and was evidenced by the following: Observations on 08/04/2025 from 11:37 AM to 12:50 PM revealed the following: A sprinkler head near the fire/smoke barrier between the east and the west wing was equipped with the wrong escutcheon leaving an approximately 2-inch space around the sprinkler head.The sprinkler head outside of resident room 8 was missing its escutcheon. The sprinkler heads near the pot storage area and the prep area in the kitchen were missing their concealed	K0353	Element 1 All sprinkler heads identified during the survey were immediately inspected and corrected. Sprinkler heads located near the East and West wings that were found to have incorrect escutcheon plates were corrected by installing the appropriate, manufacturer-approved escutcheon plates to ensure proper fit and coverage. In addition, sprinkler heads located in the pot storage and food preparation areas that were missing protective head covers were fitted with approved protective covers. All identified deficiencies were corrected and verified to ensure the sprinkler system was restored to full compliance. Element 2 All residents have the potential to be affected. No harm occurred. Element 3 Administrator re-educated maintenance staff and U.S. FOIA (b) (on compliance of K0353. Administrator or designee will audit sprinkler heads monthly for any need of repair. Administrator or designee will also review maintenance log for testing schedule compliance. Element 4 Audit findings will be reported and reviewed at QAPI monthly x 6 with any concern corrected immediately.	09/05/2025

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K0353 SS = F	Continued from page 7 sprinkler head covers.The sprinkler head outside of the laundry room was missing it escutcheon.The sprinkler system had 4 pressure gauges that were not replaced or recalibrated every 5 years. Three of 4 gauges did not have a date and 1 gauge was dated 2013. An observation at 1:00 PM revealed that the sprinkler system was equipped with an electric fire pump. In interviews at the time, the U.S. FOIA (b confirmed the observations. The Surveyor then requested the ITM of the electric fire pump and the wet sprinkler system. A record review on 08/15/2025 revealed the following: Fire pump ITM could not be found in the facility provided documentation.A quarterly wet sprinkler system inspection for Q-3 of 2024 could not be found in the facility provided documentation.A 5-year internal obstruction inspection of the wet sprinkler system could not be found in the facility provided documentation. In interviews at the time, the U.S. FOIA (b confirmed the record review. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b were informed of the deficient practices at the Life Safety Code exit conference on 08/15/2025 at 1:00 PM. N.J.A.C 8:39 – 31.2 (e) NFPA 25	K0353		
K0372 SS = F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K0372	Element I Seal penetrations that were identified were sealed with UL-listed intumescent firestop material. All non-compliant product was removed and replaced with approved firestop sealant acceptable under UL systems Element II All residents had the potential to be affected by smoke/fire. No adverse outcomes occurred. Element III	10/15/2025

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K0372 SS = F	Continued from page 8 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This STANDARD is NOT MET as evidenced by: Based on observations and interviews on 08/14/2025 and 08/15/2025 in the presence of the U.S. FOIA (b) (6) [redacted], it was determined that the facility failed to ensure that penetrations through fire/smoke barriers were protected by a system or materials capable of restricting the transfer of fire/smoke in accordance with NFPA 101:2012 Edition, Section 8.5.6, 8.3.5. This Deficient practice had the potential to affect all residents and was evidenced by the following: An observation on 08/14/2025 at 10:48 AM revealed that the fire/smoke barrier wall near resident room 33 had one, 4-inch and two, 2-inch unprotected penetrations for the pass through of wires/cables. Additionally, non-listed, yellow expanding spray foam was being used to fill penetrations. An observation at 11:41 AM revealed that the fire/smoke barrier wall between the east and west units had a 4-inch by 1-inch and a 2-inch unprotected penetration. An observation at 11:59 AM revealed that the fire/smoke barrier near room 20 had three, 2-inch unprotected penetrations for the pass through of wires/cables. In interviews at the time, the U.S. FOIA (b [redacted] confirmed the observations. The facility's U.S. FOIA (b) (6) and the U.S. FOIA (b [redacted] were informed of the deficient practices at the Life Safety Code exit conference on 08/15/2025 at 1:00 PM. N.J.A.C 8:39 – 31.2 (e)	K0372	Continued from page 8 A unit-wide inspection for any fire wall/seal penetration was completed. Administrator re-educated maintenance director and maintenance staff on compliance of K0372 requirements, proper UL firestop materials. Administrator or designee will audit monthly x6 for any firewall/seal penetrations. Element IV Audit results will be reported to monthly QAPI for 6 months. Any deficiencies found will receive immediate corrective action.	
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing	K0918	Element I Generator log updated to reflect proper monthly load testing. Immediate 30-minute full load test performed. Element II	09/05/2025

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K0918 SS = F Bldg. 01	Continued from page 9 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) This STANDARD is NOT MET as evidenced by: Based on record review and interviews on 08/14/2025 and 08/15/2025 in the presence of the U.S. FOIA (b) (6) [redacted]), it was determined that the facility failed to ensure that the Inspection, Testing and Maintenance of the emergency backup generator was in accordance with NFPA 110:2012 Edition, Sections 8.3 ,8.4 , A.8.4.1(a)(b), NFPA 99:2012 Edition, Section 6.5.4, NFPA 70 and NFPA 111 This deficient practice had the potential to affect all residents and was evidenced by the following: A record review on 08/11/2025 revealed the following: Documentation that the generator was capable of supplying service within 10 seconds, or that the generator was being tested at not less than 30 percent of the EPS nameplate KW rating was not recorded.Documentation of a 30-minute monthly load exercise was not indicated on the generator test log.	K0918	Continued from page 9 All residents had the potential to be affected by inadequate generator testing. No resident harm noted. Element Ill Administrator re-educated U.S. FOIA (b) (6) [redacted] and maintenance staff on k0918 A Generator Testing log was created to ensure compliance with monthly and bi-annual load tests. Administrator to audit generator testing logs weekly for 8 weeks. Element IV Audit Findings will be reported to monthly QAPI for 3 months. Any identified concerns will be addressed immediately.	

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K0918 SS = F Bldg. 01	Continued from page 10 In interviews at the time, the [redacted] confirmed the record review. The facility's [redacted] and the [redacted] were informed of the deficient practices at the Life Safety Code exit conference on 08/15/2025 at 1:00 PM. N.J.A.C 8:39-31.2(e) NFPA 99, 110	K0918		

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E0000	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.	E0000		09/05/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315525	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ANNEX2 B. WING	(X3) DATE SURVEY COMPLETED 12/15/2025

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K0000 Bldg. 01	INITIAL COMMENTS An offsite/desk review of the facility's Plan of Correction was conducted on 12/15/2025 in relation to the 8/21/2025 Life Safety Code survey. The facility 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 Occupancy.	K0000		12/15/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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