

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

PRINTED: 11/29/2022  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>315465</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>09/02/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MANHATTANVIEW NURSING HOME</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3200 HUDSON AVENUE</b><br><b>UNION CITY, NJ 07087</b>  |  |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   |  | (X5)<br>COMPLETION<br>DATE   |
| F 000   | INITIAL COMMENTS<br><br>Complaint #: NJ00134704, NJ0133695,<br>NJ00126162, NJ00135589, NJ00132483<br><br>Census: 76<br><br>Sample Size: 6<br><br>THE FACILITY IS NOT IN COMPLIANCE WITH<br>THE REQUIREMENTS OF 42 CFR PART 483,<br>SUBPART B, FOR LONG TERM CARE<br>FACILITIES, BASED ON THIS COMPLAINT<br>VISIT.  | F 000  |  |  |  |
| F 658<br>SS=D   | Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility,<br>as outlined by the comprehensive care plan,<br>must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced<br>by:<br>COMPLAINT# NJ00133695<br><br>Based on interview, record review, and review of<br>pertinent facility documents on 9/1/20 and 9/2/20,<br>it was determined that facility staff failed to<br>transcribe a Physician's Order (PO) on admission<br>to the Treatment Administration Record (TAR) for<br>[REDACTED] sampled Residents (Resident #2).<br><br>This deficient practice was evidenced by the<br>following:<br><br>Reference: New Jersey Statutes, Annotated Title | F 658  | F-658<br>1. Resident #2 the order for [REDACTED] was<br>not transcribed to the TAR. Resident # 2<br>no longer resident of this facility.<br>2. All residents have the potential to be<br>affected by this deficient practice when<br>orders are not followed. An audit was<br>completed by the Director of Nurses of all<br>residents with [REDACTED] orders, to ensure all<br>orders are carried out appropriately.<br>3. An In-service to all nurses was<br>completed by the Director or nursing, to<br>ensure when new orders are written on<br>the physician order form, they are carried<br>out on the TAR. |  | 9/15/20  |

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

TITLE

(X6) DATE

Electronically Signed

09/09/2020

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

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

PRINTED: 11/29/2022  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |                            |  |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>315465</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>09/02/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MANHATTANVIEW NURSING HOME</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>3200 HUDSON AVENUE<br/>UNION CITY, NJ 07087</b>  |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   | (X5)<br>COMPLETION<br>DATE |  |
| F 658   | <p>Continued From page 1</p> <p>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."</p> <p>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."</p> <p>On 9/1/20 at 8:59 AM, the Licensed Practical Nurse/Unit Manager (LPN/UM) informed the surveyor during an interview that the [REDACTED] order should be written in the Physician's Order and transcribed in the TAR. He stated that it was the nurse's responsibility to check the resident's [REDACTED] and the order.</p> <p>According to Resident #2's Face sheet (an admission summary), the resident was admitted to the facility on [REDACTED], with diagnoses which included but were not limited to [REDACTED]</p> | F 658  | <p>4. The Director of Nurses or Assistant Director of Nurses will audit the accuracy by [REDACTED] orders, as they are written weekly x 30days. All findings will be reviewed at the quality assurance meeting x 3 quarters.</p> |                            |  |

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

PRINTED: 11/29/2022  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |  |  |                            |  |
|---|--|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>315465</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><b>09/02/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MANHATTANVIEW NURSING HOME</b> |  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>3200 HUDSON AVENUE</b><br><b>UNION CITY, NJ 07087</b>                        |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 658   | <p>Continued From page 2</p> <p>[REDACTED]</p> <p>A review of the Minimum Data Set (MDS), an assessment tool used to facilitate care management dated [REDACTED], indicated a Brief Interview for Mental Status (BIMS) scored at [REDACTED] indicating Resident #2's cognition was [REDACTED]. The MDS further indicated that the resident had [REDACTED]</p> <p>The surveyor reviewed the Physician's Order, which revealed that Resident #2 had a physician order dated [REDACTED] indicating [REDACTED] and check to [REDACTED] every shift. The Nurse Practitioner signed the order for [REDACTED]</p> <p>A review of the [REDACTED] TAR showed that the above orders for check [REDACTED] nurses were signed every shift, and the [REDACTED] were within normal limits.</p> <p>Further review of the [REDACTED] TAR did not show that the order for [REDACTED] was transcribed to the TAR.</p> <p>A review of the Nurse's Notes dated [REDACTED] signed by a Licensed Practical Nurse (LPN), revealed that Resident #2 was admitted to the facility with 2 [REDACTED]</p> <p>On 9/2/2020 at 8:30 AM, the Director of Nursing (DON), in the presence of the Administrator, informed the surveyor that as facility practice, it was the nurse in the unit that obtain a physician order upon admission and transcribes the orders in the TAR and MAR (Medication Administration Record). The DON stated that it was her</p> | F 658  |  |                            |  |

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

PRINTED: 11/29/2022  
FORM APPROVED  
OMB NO. 0938-0391

|   |   |  |  |                            |  |
|---|---|--|--|----------------------------|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>315465</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____   |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>C</b><br><br><b>09/02/2020</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MANHATTANVIEW NURSING HOME</b> |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>3200 HUDSON AVENUE<br/>UNION CITY, NJ 07087</b>                          |                            |  |
| (X4) ID<br>PREFIX<br>TAG  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |  |
| F 658   | <p>Continued From page 3</p> <p>responsibility in the following day to check the new resident's admission orders to make sure that the physician's orders were carried out correctly and appropriately.</p> <p>On that same date and time, the DON stated that it was the LPN/UM who obtained an admission order of Resident #2 and transcribed to the TAR that included the order for [REDACTED]. She further stated, "I don't know how it was missed," the order of [REDACTED] that was not carried over to the TAR.</p> <p>On 9/2/2020 at 8:43 AM, the LPN/UM informed the surveyor that he was the one who wrote the orders in Resident #2's physician order form and transcribed to the MAR and TAR. He stated, "I don't know how I missed it," the [REDACTED] order that was not transcribed to the TAR.</p> <p>A review of the [REDACTED] Administration Policy and Procedure dated 7/20/2020, provided by the Administrator, indicated, "Preparation: Verify that there is a physician's order for this procedure; review the physician's orders or facility protocol for [REDACTED] administration .....Report other information in accordance with facility policy and professional standards of practice."</p> <p>NJAC 8:39-11.2 (b)</p> | F 658  |  |                            |  |