STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 3/8/2022 Census: 120 Sample: 24 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.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F 578		3/31/22

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

Electronically Signed | 03/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to evaluate residents for advance directives (AD) and/or Physician Orders for Life Sustaining Treatment (POLST) related to end of life preferences. This deficient practice was observed for 3 of 26 residents reviewed for Advance Directives and POLST, Residents #94, #95, and #98 and was evidenced by the following: 1. The Admission Record for Resident #94 indicated that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted] Review of Resident #94's Significant Change Minimum Data Set (MDS), an assessment tool	F 578	1. The following corrective actions have been accomplished for the identified deficiency: - There was no negative outcome for residents #94, #95, and #98, and all these residents were offered and POLST and Advance Directive were updated and corrected. 2. All residents in the facility have the potential to be affected by the deficient practice of not being given the opportunity to complete a POLST and Advance Directives. 3. The following measures have been put into place to prevent the deficient practice from recurring: - Director of Social Services immediately in-serviced on facility policy for POLST and Advance Directives. - All new resident charts will have a blank POLST form added to them prior to	

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F 578	Continued From page 2 used to facilitate the management of care dated [redacted] reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] which indicated Resident #94 had [redacted]. Review of the [redacted] physician's orders (PO) revealed that the resident was a Full Code Status, indicating that all life saving measures should be implemented if the person's heart stopped beating and or if they stopped breathing. The surveyor was unable to locate any documentation that would indicate that the resident's end of life wishes had been discussed or addressed with the resident or resident's representative. During an interview on 2/28/22 at 10:53 AM, Resident #94 told the surveyor that no one at the facility had asked them about their end of life wishes. On 3/1/22 at 11:37 AM, during an interview with the Director of Social Services (DSS), she could not explain why the POLST, or an AD was not discussed with Resident #94. 2. The Admission Record for Resident #95 indicated that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. Review of Resident #95's Admission MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] which indicated that Resident #95 had [redacted]. Review of the [redacted] PO revealed that the	F 578	admission. - Advance Directive form, a part of initial social service documentation for new admissions, will be updated to note the exact documentation relating to POLST, and Advance Directive has been provided to the resident. - Within two weeks of admission, it will be noted in the resident chart whether the resident would like to complete a POLST and Advance Directive. - All resident charts have been audited to ensure that all residents have been offered the opportunity to have a POLST and Advance Directive. 4. The Director of Social Services or designee will audit a minimum of 10 new admission charts monthly for 90 days, to ensure that all residents have been offered the opportunity to have a POLST and Advance Directive, and the findings will be reported to the QAPI committee on a quarterly basis for 3 months, and if no issues are noted the audit will be 6 months intervals, and if no issues thereafter yearly.	

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F 578	Continued From page 3	F 578		

resident was a Full Code Status. The surveyor was unable to locate any documentation that would indicate that the resident's end of life wishes had been discussed or addressed with the resident or resident's representative.

On 3/1/22 at 11:14 AM, during an interview with the DSS, she could not explain why the POLST, or an AD was not discussed with Resident #95's representative.

3. The Admission Record for Resident #98 indicated that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]

Review of Resident #98's Admission MDS dated [redacted] reflected that the resident had a BIMS score of [redacted] which indicated Resident #98 had [redacted].

Review of the [redacted] PO revealed that the resident did not have a Code Status documented. The surveyor was unable to locate any documentation that would indicate that the resident's end of life wishes had been discussed or addressed with the resident or resident's representative.

During an interview on 2/28/22 at 1:29 PM, Resident #98 told the surveyor that no one at the facility had asked them about their end of life wishes.

On 3/1/22 at 12:57 PM, during an interview with the DSS, she could not explain why the POLST, or an AD was not discussed with Resident #98.

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F 578	Continued From page 4 Review of the "Procedure" section of the Facility's policy and procedure entitled, "Practitioner Orders for Life-Sustaining Treatment (POLST)" reviewed by the facility on August 2021 indicated: 1. At the time of admission the facility will determine whether the individual has completed a POLST form. 3. If the individual does not have a POLST form at the time of admission, the facility will introduce POLST within 14 days of admission. 10. If the individual, or when the individual lacks decision-making capacity, the legally recognized health care decision-maker, expresses concern about the POLST form, or if there has been a significant change in the individual's condition or wished, then the physician/nurse practitioner will be notified with 24 hours to discuss the potential changes with the individual or, if the individual lacks decision-making capacity, the legally recognized decision-maker. On 3/7/22 at 1:40 PM, the survey team discussed the above observations and concerns with the Licensed Nursing Home Administrator and DON. No further information was provided by the facility. N.J.A.C. 8:39-4.1 (a) 4	F 578		
F 658 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:	F 658		5/12/22

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F 658	Continued From page 5 Based on observation, interview, and record review it was determined that the facility failed to accurately transcribe a physician's order (PO) onto the March 2022 Medication Administration Record (MAR) and failed to accurately document proper placement on the [redacted] Protocol ([redacted]) sheet in accordance with professional standards of practice. This deficient practice was identified for 1 of 24 residents reviewed for standards of practice, Resident #212 and was evidenced by the following: Reference: New Jersey Statues, 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 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 a 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."	F 658	F658: Services Provided Meet Professional Standards • 1. The following corrective actions have been accomplished for the identified deficiency: • There was no negative effects for resident #212. • DON immediately clarified the [redacted] with dietician and MD and correct order was placed on MAR • Resident was immediately assessed to ensure correct placement of the [redacted] at that time. • 2. Any resident with an [redacted] had the potential to be affected by the deficient practice. • An audit of all residents on [redacted] was conducted by the DON and no inaccuracies in physician orders were identified, • All other resident with [redacted] were assessed for correct placement • 3.The policy for [redacted] and physician's orders were reviewed and updated. • All nurses were re-educated on the [redacted] and physician's orders policies. • All nurses were re-educated on checking for [redacted] placement. • 4.Don or designee will audit RD and physician's orders for resident's [redacted] weekly for 90 day and reported to the QAPI committee x 3 months. • DON will audit medical record 2 times	

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F 658	Continued From page 6 1. On 2/28/22 at 11:12 AM, the surveyor observed Resident #212 in bed. The surveyor observed the resident had a [redacted]. The [redacted] was observed with [redacted] formula infusing at [redacted] milliliters (ml) per hour via an [redacted] (a [redacted]. On 3/7/22 at 10:15 AM, the surveyor observed Resident #212 in bed. The surveyor observed [redacted] infusing at [redacted] ml per hour [redacted]. The surveyor reviewed the Admission Record which reflected Resident #212 was admitted to the facility with diagnoses which included but were not limited to [redacted]. Review of the resident's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] assessed that Resident #212 was rarely/never understood, indicating [redacted]. Review of the Enteral Protocol dated [redacted] and signed by the Physician documented that [redacted] ml/hour (hr.) [redacted] to run continuous until seen by dietician was ordered. Review of the NutrasourceRD dated [redacted] and signed by the Physician documented that [redacted]-Goal rate of [redacted] ml/hr. was ordered.	F 658	a week for 90 days to ensure [redacted] placement is being checked and results will be reported to the QAPI committee x 3 months.	

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F 658	Continued From page 7	F 658		

The surveyor reviewed the resident's [redacted]" documentation sheet [redacted]). The [redacted] documented, [redacted] infused at a [redacted] ml/hr. [redacted] run continuously. The [redacted] was signed by nursing daily, from 3/1/22-3/7/22 as administered.

2. A further review of the [redacted] documented "Check [redacted] for proper placement prior to each [redacted], medication administration." The [redacted] required recorded entries for all three nursing shifts daily.

Review of the EP indicated that nursing failed to document proper placement checks on 3/6/22 and 3/7/22 for the 11:00 PM-7:00 AM shift. The EP also indicated that there was no documented evidence that proper placement was checked from 3/1/22 to 3/7/22 on the 7:00 AM to 3:00 PM shift. Further review of the same [redacted] indicated that nursing failed to document proper placement checks on 3/1/22, 3/4/22, and 3/6/22 for the 3:00 PM to 11:00 PM shift.

The surveyor reviewed the [redacted] with the Registered Nurse (RN), who acknowledged that he should have clarified the PO and should be signing for the [redacted] which was being administered. The RN further acknowledged that nursing should have documented checking the proper placement of the [redacted] on the [redacted] daily and every shift.

On 3/7/22 at 12:25 PM, the surveyor interviewed the Director of Nursing (DON) who stated that the [redacted] should have been updated when the [redacted] ordered on [redacted] was changed to [redacted] on [redacted] The DON

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F 658	Continued From page 8 acknowledged that nursing should sign for the formulation that was being administered and the placement check of the [redacted] daily, every shift. On 3/7/22 at 12:39 PM, the surveyor interviewed the Registered Dietitian (RD) who stated that she had faxed her recommendation for [redacted] at [redacted] mL/hr. to the Physician. Review of the subsection "Procedure" of the Policy and Procedure titled, "[redacted] last revised and reviewed by the facility on 1/2/22 documented: 1. Verify physician's orders. 3. Prepare [redacted] as ordered by physician. 6. Assess placement of [redacted] 16. Document administration of [redacted] on Medication Administration Record including Date, [redacted]. On 3/7/22 at 1:40 PM, the survey team discussed the above observations and concerns with the Licensed Nursing Home Administrator and DON. No further information was provided by the facility.	F 658		
F 689 SS=D	NJAC 8:39-27.1 (a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		3/31/22

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F 689	Continued From page 9 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to report a witnessed fall incident, complete a thorough fall investigation, implement safety measures and revise interventions for a resident who had a history of falls. This deficient practice was identified for [redacted] residents, Resident #49, reviewed for falls and was evidenced by the following: On 2/28/22 at 11:32 AM, the surveyor observed Resident #49 out of bed seated in a wheelchair in the [redacted] watching TV and conversing with another resident. The resident informed the surveyor, that they had a [redacted] and that before they were admitted to the facility, they had a '[redacted] and fell. The resident stated that when they were admitted to the facility after their fall, they were [redacted] and [redacted] for themselves. Resident #49 further stated that they had regained a lot of their [redacted], but still had periods of [redacted]. Resident #49 informed the surveyor that their main mode of locomotion on the unit was the wheelchair due to their [redacted] Review of the resident's Admission Record revealed that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted].	F 689	• 1. The following corrective actions have been accomplished for the identified deficiency: • Resident #49 sustained no injuries related to the fall. Rehab was notified of the incident upon return from the hospital and the resident was re-evaluated by rehab and was provided a new wheelchair that was appropriate for the resident and was trained how to use the chair and taught how to use the wheelchair with [redacted] and staff will ensure proper use of [redacted] in place and safety. • 2. Any resident who sustained a fall is affected by the deficient practice. • A Review of all residents falls for the past 90 days to ensure that timely reported, thorough investigations, and appropriate investigations will be conducted • 3. All members of the interdisciplinary team (nursing, rehab, activities, and housekeeping) were immediately re-educated on the falls policy was reviewed and updated, to include a log to track all aspects of reporting, documenting, and following up on falls. Including reporting in a timely manner investigating thoroughly as well as identifying appropriate interventions to prevent reoccurrences. • 4. DON or designee will review the facility shift report daily for 90 days to ensure that all falls were reported. The tracking log will be utilized to ensure all	

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F 689	Continued From page 10 Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected the resident had a brief interview for mental status score of [redacted] which indicated [redacted]. Review of [redacted] of the MDS for functional status, indicated the resident required extensive assistance with one-person assistance for transfers, dressing, toilet use and bathing and minimal assistance with one-person assistance for bed mobility, locomotion on the unit and eating. On 3/2/2022 at 10:35 AM, the surveyor interviewed Resident #49 who explained that their wheelchair flipped backwards, and they hit their [redacted]. Review of the Incident Report (IR), provided by the Director of Nursing (DON) revealed the resident had a fall on [redacted] at 3:30 PM. The IR included that, Resident #49 stated that they were going into the elevator and their wheelchair tipped backwards when pulling themselves onto the elevator. Review of the Licensed Practical Nurse/ Unit Manager (LPN/UM) Employee Statement dated [redacted], documented that Resident #49 stated that they were backing into the elevator when the wheelchair tipped over backwards. The statement documented that there were no apparent injuries noted. The resident was returning from an activity on the [redacted] floor. Included in the statement was an entry that at around 4:30 PM the resident complained of [redacted]. The statement added that the Medical	F 689	aspects of the fall policy are being met. And report the results to the QAPI committee for 3 months.	

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F 689	Continued From page 11	F 689		

Doctor was made aware, and the wife was informed. Vital signs were documented as follows: Blood Pressure [redacted], Pulse [redacted] Respirations [redacted] Temperature [redacted]. The Physician ordered the resident sent out to the ER for a [redacted] scan of the resident's [redacted]

Review of the DOR employee statement reflected that she and a recreation aide (RA) were transporting members from the Resident Council Meeting to their respective floors. The statement documented that the DOR and RA reversed Resident #49's wheelchair and attempted to pull them backwards into the elevator. The statement further explained that the wheelchair tilted backwards after the front wheels became stuck in the elevator gap and the resident's wheelchair fell backward.

On 3/2/22 at 10:00 AM, the surveyor interviewed the Licensed Practical Nurse/ Unit Manager (LPN/UM) who stated that it was Resident #49 who informed her that they had a fall on [redacted] and that neither the DOR nor the RA informed her of the incident.

On 3/2/22 at 10:09 AM, the surveyor interviewed the DOR who stated that she witnessed the resident fall backward; assisted the resident back up; asked if they were okay. The DOR added that the resident seemed fine, was [redacted] The DOR stated that she continued to transfer Resident #49 to the [redacted] floor and then continued bringing the other residents to their respective floors, without reporting the incident to the nurse.

The DOR explained that when she returned to the

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[redacted] floor about 15 minutes after dropping off Resident #49, the LPN/UM informed her that Resident #49 complained of hitting their [redacted] The DOR then confirmed that the resident had fallen in the elevator. The DOR acknowledged that she should have immediately reported the incident to the nurse.

On 3/2/22 at 10:35 AM, the surveyor interviewed Resident #49 who stated that a staff member pulled the wheelchair backwards and assisted the resident into the elevator. Resident #49 explained that the wheels got stuck and caused the wheelchair to fall backwards. Resident #49 stated that they hit their [redacted] and informed the staff member of the injury.

Resident #49 added that when they were left on their residing floor, they told the LPN/UM of the incident. Resident #49 included that when they felt [redacted], the LPN/UM then transferred the resident to the Emergency Room (ER) where they had a [redacted] of the [redacted]. The resident stated that the [redacted] revealed that there were no injuries. Resident #49 added that they stayed overnight for observation and transferred back to the facility the next day.

A review of the resident's individualized, comprehensive care plan (CCP) for "[redacted]," revised on [redacted] had the following interventions, "Assess fall risk on admission, quarterly and when necessary; sent to ER; Refer to Physical Therapy."

On 3/2/22 at 12:37 PM, the survey team interviewed the DON who stated that the RA assisting with the transportation of the resident

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	315465	A. BUILDING _____ B. WING _____	03/08/2022

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should have written an employee statement regarding the incident. She further indicated that the DOR statement was incomplete and should have had more details. The DON added that the DOR should have immediately notified the LPN/UM and nursing supervisor.

The DON explained the procedure for "Incident/Accident" investigations (I/A) a Registered Nurse should be notified immediately and should assess the resident. The DON added that the nurse and staff should complete employee statements and notify the physician as well as the family.

The surveyor requested the completed investigation. The DON searched the computer and stated that she was unable to locate the completed investigation.

On 3/2/22 at 12:58 PM, the surveyor interviewed the Recreation Aide (RA) who stated she was holding the handles of the wheelchair while pulling Resident #49 backwards into the elevator when the wheels got stuck and the resident in the wheelchair fell backwards. The RA further stated that she wasn't asked to complete an employee investigation statement. The RA stated that the DOR completed the employee investigation statement, "My boss completed the employee statement since it wasn't my fault."

The surveyors asked the RA if she had any formal transport of resident's training. The RA replied that she did not.

On 3/2/22 at 1:45 PM, during the resident council meeting, Resident #49's roommate informed the surveyors that Resident #49 couldn't attend the

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F 689	Continued From page 14 meeting because they had fallen in the elevator. On 3/2/22 at 2:55 PM, the surveyor interviewed the Rehabilitation Director (RD) who stated that he was not aware that Resident #49 fell on [redacted] and that the resident needed to have their wheelchair evaluated. The RD stated that he was asked to put anti tippers on the resident's wheelchair after the resident's [redacted] fall in the elevator. The RD stated that when he evaluated Resident #49's wheelchair for fall risk, the outcome led the RD to provide Resident #49 with a new wheelchair with [redacted] on it. On 3/2/22 at 3:15PM, the surveyor interviewed the 3 PM-11PM shift RN/S, who stated that she made a mistake with her late entry regarding the fall on [redacted] The RN/S further stated that at first, she didn't believe the resident because the DOR told her the resident didn't fall. The RN/S further investigated the fall and after further discussion with Resident #49 concluded that the fall did take place. On 3/3/22 at 8:56 AM the DON provided the surveyor with a one-page "investigation summary" from Resident #49's [redacted] fall, which did not include interviews of the RA and failed to reflect that a thorough investigation had been completed for the incident. On 3/7/22 at 1:40 PM, the surveyor interviewed the DON who stated that she intended to refer Resident #49 to the Rehabilitation Department after the first fall on [redacted] but "didn't." The surveyor reviewed the "Policy" section of the "Incident and Accident Policy," last reviewed by the facility on 1/2022 which reflected:	F 689		

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"It is the policy of this facility that accidents/ incidents involving resident care will be investigated and documented on the Resident Incident Report, to enable the facility to evaluate care given to residents, to assist in prevention of incidents, and evaluate interventions implemented in the event of an incident. An accident /incident is any unusual event, occurrence, or happening which may or may not result in injury or illness to a resident."

Review of the "Protocol section" of the "Incident and Accident Policy" documented:
1. Accident/Incident reports are initiated by a clinician as soon as the occurrence is discovered or reported.
2. A thorough investigation and follow-up will be completed within five working days. A summary of the accident/incident will be documented."

Review of the "Procedure section" of the "Incident and Accident Policy" documented:
1. Licensed nurse/supervisor will complete an assessment of the resident/patient and protect resident/patient from further immediate harm or potential harm.

5. Licensed nurse/supervisor initiates the investigation to determine cause. Examples may include, but are not limited to:
-Interview affected resident if possible.
-Interview all potential witnesses, to include roommate, other residents, visitors, family members and staff.
-Observe the immediate surrounding environment.
-Review medication regimen

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6. Review of the accident/incident report will be completed by the DON and/or Nurse Manager within 24 hours.

8. Nurse Manager/DON completes follow-up and resolution to the investigation.

9. DON/designee completes report with findings and conclusions.

Review of the "Fall Prevention and Management Program" policy and procedure last reviewed by the facility on January 10, 2022, reflected:

Documented under the section titled, "Purpose: The purpose of the Falls Prevention and Management Program is to develop, implement, monitor, and evaluate an interdisciplinary team falls prevention approach and management strategies that foster resident independence and quality of life while ensuring safety for the resident and other residents and staff.

The program focuses on reducing the incidence of residents' falls and mitigating risks of falls through a resident focused, team approach which ensures that a resident's environment and social, physical, cognitive, and emotional strengths are supported. The program ensures team training, communication, and effective care planning."

Documented in the "Fall Prevention and Management Program" under the section titled, "Program Objectives:"
1.To improve and maintain a resident's optimal functional level and quality of life.
2. To identify and reduce or eliminate environmental risk factors for residents.
3. To identify and reduce or eliminate health risk

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factors for residents
4. To reduce the frequency of falls.
5. To reduce the severity of injuries from falls.
6. To ensure best practice interventions for residents who have fallen.
5. To monitor and track trends related to resident falls.

Documented under the section titled, "A. Fall Prevention" of the "Fall Prevention and Management Program" subsection, "Registered Nursing Staff:"
4. Refer the resident to the interdisciplinary team based on their level of risk and/or as deemed appropriate and initiate strategies/activities to reduce/minimize the risk of falls.
5. Assess for and implement nursing restorative/rehabilitation activities as part of care planning.

Documented under the section titled, "B. Fall and Post Fall Assessment and Management"
"When a resident has fallen, the resident will be assessed regarding the nature of the fall and associated consequences, the cause of the fall and the post fall care management needs."

Documented under the section titled, "B. Fall and Post Fall Assessment and Management" subsection, "Person witnessing the fall or finding the resident after the fall:"
3. Notify the registered nursing staff/Nursing Supervisor.

Documented under the section titled, "B. Fall and Post Fall Assessment and Management" subsection, "Registered Nursing Staff:"
1. Complete the head to toe assessment.
5. Initiate neuro-checks for all unwitnessed falls

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F 689	Continued From page 18 and witnessed falls that have resulted in a possible head injury. Follow neuro-check protocol unless otherwise specified by the MD. 9. Redo the Fall Risk Assessment and modify the plan of care in collaboration with the interdisciplinary team. Documented under the section titled, "B. Fall and Post Fall Assessment and Management" subsection, "Staff Training and Education" 1. Provide orientation and training on the falls prevention and management program (policy, procedures, tools) including the importance of the program and the risk to residents' health due to falls On 3/7/22 at 1:45 PM, the survey team met with the Licensed Nursing Home Administrator and DON to discuss the above observations and concerns. No further information was provided by the facility. NJAC: 8:39-27.1	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 695	• 1. The following corrective actions	3/31/22

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F 695	Continued From page 19 review, it was determined that the facility failed to maintain necessary [redacted] care and services for a resident who was receiving [redacted]) and [redacted] treatment according to the standards of practice. The deficient practice was identified for [redacted] residents (Resident #54) reviewed for [redacted] care. This deficient practice was evidenced by the following: On 2/28/22 at 10:41 AM, the surveyor observed Resident #54 in bed in their room, with [redacted] in use [redacted] at [redacted] attached to the [redacted] r (a medical device used for delivering [redacted] There was no date indicated in the [redacted] when it was last changed. The surveyor also observed a [redacted] placed inside the drawer next to the plastic bag. The [redacted] was dated [redacted] indicating the date when it was changed. A review of the resident's face sheet (an admission summary) reflected that Resident #54 was admitted to the facility with diagnoses that included [redacted] A review of the 2/17/22 Comprehensive Minimum Data Set, an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status score of [redacted] indicating that the resident was unable to complete the interview. [redacted] for daily decision revealed that Resident #54 had [redacted].	F 695	have been accomplished for the identified deficiency: • Resident #54 was not negatively affected by improper storage and dating of [redacted], and [redacted] changed immediately, dated, and put in proper storage. • 2. All residents receiving current [redacted] treatment and [redacted] r treatments are audited. [redacted], and equipment currently used were checked to ensure proper storage and dating. • 3. All nurses were re-educated about proper storage and dating of [redacted] and equipment and during rounds incorporated an audit tool to ensure that it is properly done. • 4. DON/designee, will observe currently 3 residents per week x 90 days to ensure that [redacted] equipment is in proper storage and dated properly. and the findings will be reported to the QAPI committee on a quarterly basis for 3 months, and if no issues are noted the audit will be 6 months intervals, and if no issues thereafter yearly.	

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F 695	Continued From page 20 On 2/28/22 at 11:05 AM, the nurse assigned to Resident #54 was brought inside the room and during the interview, the nurse stated that she does not know when the [redacted] was last [redacted]. The nurse further stated that the [redacted] must be dated when it was changed. The surveyor showed the [redacted] with a date of [redacted] to the nurse. The nurse stated that when the [redacted] is not in use, it must be placed inside the plastic bag for proper storage. The nurse also stated that the [redacted] was not changed since the date indicated. A review of the [redacted] Physician's Order Form revealed that there was an order dated [redacted] for [redacted]; change [redacted] weekly on Sundays on 11-7 shift. Further review of the physician's order revealed an order dated [redacted] [redacted] give TID (three times a day) [redacted] x 30 days. The surveyor reviewed the facility's Policy and Procedure titled, [redacted] Administration under "#12 Care and Use of Reusable [redacted] (g.) Change [redacted] weekly." On 3/7/22 at 1:30 PM, the surveyor brought the above concern to the Administrator and Director of Nursing. No additional information was provided. NJAC 8:39-11.2 (b) 27.1(a) 19.4 (k)	F 695		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)	F 711		3/31/22

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F 711	Continued From page 21 §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility's physician failed to conduct a face-to-face visit at a required interval and to assure that the physician responsible for supervising the care of the residents signed and dated the monthly physician's orders to ensure that the residents current medical regimen was appropriate. This deficient practice was observed for 2 of 24 Residents reviewed, Resident #48 and #50 and was evidenced by the following: 1.) On 2/28/22 at 10:23 AM, the surveyor observed Resident #48 in bed, awake, watching TV. The surveyor verified the last time the physician visited the resident. Resident #48 responded "it's been a long time." A review of the resident's face sheet (an admission summary) reflected that Resident #48 was admitted to the facility with diagnoses that	F 711	1) Residents #48 and #50 have been seen by their Physician and progress notes have been updated and signed. 2) All Residents in the building have the potential to be affected. 3) All Physicians have been notified by the facility□s Medical Director on 03/15/22 to review their charts to ensure physician visits and progress notes have been entered in accordance with federal regulations. A copy of the facility policy and procedure will be sent to all attending Physicians for review. All Physicians verbalized understanding and will ensure that all residents are seen and progress notes are entered in a timely	

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F 711	Continued From page 22 included [redacted] A review of the Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate care management dated [redacted], indicated a Brief Interview for Mental Status (BIMS) scored at [redacted], which indicated that the resident was [redacted]. A review of Resident #48's Physician's Order Sheets (POS), from [redacted] through [redacted], revealed that the resident's physician did not sign and date the monthly Physician's Orders indicating that the resident's medications were never reviewed. A review of the Physician's Progress Notes revealed that the last progress note and face to face visit from the Physician was dated [redacted] There were no further progress notes located in the resident's medical records. 2.) On 2/28/22 at 10:43 AM, the surveyor observed Resident #50 in the day room attending an activity. The surveyor interviewed the resident who can only speak and understand [redacted]. A review of the resident's face sheet reflected that Resident #50 was admitted to the facility with diagnoses that included [redacted] and [redacted]. A review of the QMDS, an assessment tool used to facilitate care management dated [redacted], indicated that the resident was unable to complete the BIMS interview due to [redacted] for both [redacted] and [redacted] for daily [redacted]	F 711	manner. 4) DON/designee will audit ten (10) resident charts per week for 4 weeks then five (5) resident charts per week for four (4) weeks. a) All results of the monitoring will be presented to the QA committee for review and any additional monitoring or modification of this plan monthly for 3 months. b) The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. c) The Date of Completion is March 31, 2022. The administrator is responsible for the implementation of the Plan of Correction.	

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F 711	Continued From page 23 revealed [redacted] A review of Resident #50's POS, from [redacted] through [redacted], revealed that the resident's physician did not sign and date the monthly Physician's Orders indicating that the medications were never reviewed. A review of the Physician's Progress Notes revealed that the last progress note and face to face visit from the Physician was dated [redacted] There were no further progress notes located in the resident's medical records. On 3/8/22 at 10:08 AM, the surveyor interviewed the Physician via a phone conversation. The Physician stated that he missed signing the POSs for both Residents #48 and #50. The Physician informed the surveyor that the progress notes were stored in his personal computer and was not accessible to the facility. A review of the facility's policy titled, "Physician Visits: Initial Medical Assessment and Routine follow up visits" under Routine follow up visit "#1. The physician will visit the resident as follows: At least every 60 days thereafter." A Policy titled, "Physician Order" indicated that "Physician orders will be dated and signed according to state and federal guidelines." On 3/7/22 at 1:30 PM, the surveyor brought the concern to the Administrator and the Director of Nursing regarding the physician visits. There were no additional information provided. NJAC 8:39-27.1	F 711		

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F 812	Continued From page 24	F 812		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain acceptable labeling and dating of foods in the dry storage room including discarding food items past their recommended expiration dates. This deficient practice was observed during kitchen tour and was evidenced by the following: On 2/28/2022 at 9:20 A.M., the surveyor toured the kitchen with the Dietary Director (DD). During the tour of the dry storage area with the DD, the surveyor observed: 1. Five boxes of 32 ounce (oz.) Baking Soda	F 812	F812 1. The expired items were immediately disposed of, items with a manufactures code were identified with the proper expiration dates and were labeled. 2. All resident's have the potential to be affected by the deficient practice of not disposing of expired food, and items not being labeled with the correct expiration date. 3. The Food Service Director and all	3/31/22

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F 812	Continued From page 25 with an expiration date of 12/18/2021 on the shelf. 2. Five cans of 106 oz. Fruit Mix dated with an expiration date of 1/21/21. 3. Seven cans of 6 pounds (lbs.) 10oz Pineapple Chunks with an expiration date of 10/1/21. 4. Multiple items were noted received from the distributor without labels indicating, "use by" and/or expiration dates. Instead, these items were labeled with a manufacture's code. When interviewed by the surveyor, the DD was unable to state the date the item was received and/or the "use by" date of the following items: a. Four cans of 6 lbs. Mashed Potatoes b. Seven cans of 105 oz. Diced Tomatoes c. Six cans of 6 lbs 5oz Three Bean Salad d. One can of 104 oz. Sliced Beets e. Four cans of 110 oz. Chickpeas f. Four cans of 6 lbs. 12oz Vegetarian Beans g. Five cans of 3 lbs 14oz Sliced Mushrooms h. Six cans of 117 oz. Cranberry Sauce i. Two cans of 108 oz. Breakfast Skillet j. Two containers of 1 gallon each Buttermilk Ranch Dressing k. Two containers of 1 gallon each Creamy Ranch Dressing l. One container of 5 lbs Peanut Butter During the interview with the surveyor, the DD could not identify the expiration dates based on the manufacturing code system. The DD could not explain why the expired baking soda was not removed from the dry storage area. The DD was unable to produce a facility policy for storage of food and supplies. On 3/3/2022 at 2:30 PM. The surveyor discussed	F 812	kitchen staff were in serviced on making sure all expired food are disposed of, how to read the manufacturer codes to identify the expiration date, and to make sure all food items have a expiration date. 4. The Food Service Director will audit the kitchen weekly for two months. The Director will be looking to make sure all items have an expiration date, and making sure there are no expired items in the kitchen. The finding will be reported to the QAPI committee on a quarterly basis for 3 months. There after every 6 months, and then yearly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 26 kitchen concerns with the Administrator and Director of Nursing. NJAC 8:39-17.2(g)	F 812		
F 882 SS=D	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP 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 facility staff interviews and review of pertinent facility documentation on 3/3/2022, it was determined that the facility failed to provide a	F 882	• 1. The following corrective actions have been accomplished for the identified deficiency:	3/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 882	Continued From page 27 designated qualified Infection Prevention and Control Nurse. This deficient practice is evidenced by the following: During an interview on 3/2/2022 at 2:59 P.M., the Assistant Director of Nursing (ADON), stated that she has been certified as the Infection Prevention and Control Nurse (IPC) since 9/23/2021, and that she is the only Infection Prevention and Control Nurse at this time in the facility. The ADON further stated that she is working full time as the ADON and the IPC. She stated that on [redacted], she completed her Centers for Disease Control and Prevention training, receiving her certification as a Nursing Home Infection Preventionist. On 3/3/2022 at 10:40 AM, the Director of Nursing (DON) supplied the surveyor with the paperwork for the IP designee, ADON. The ADON was also practicing as the IPC and received her IP certification on 9/23/21. During an interview on 3/3/2022 at 1:17 P.M. with the Regional Registered Nurse (RRN), DON and ADON, the surveyor identified that the ADON did not meet the qualifications to be the IPC. The ADON did not have the required 5 years of experience as an IPC, and it was not her only designated job title. Reference: State of New Jersey Department of Health Executive Directive No 20-026-1 dated October 20, 2020, revealed the following: ii. Required Core Practices for Infection Prevention and Control: Facilities are required to have one or more	F 882	• No residents were negatively affective by this deficient practice • 2.All residents have the potential to be affected by this deficient practice. • 3.The Administrator /DON have reached out to multiple professional recruiters in order to fill the infection preventionist position with a nurse who possess all requirement stated in the regulation. The Administrator/DON, designee will review all received resumes/applications daily, schedule interviewed as soon as possible in order to fill the position. • 4. The Administrator will report to the Qapi committee on a monthly basis until the appropriate candidate is identified of what steps are being taken to find a qualified and appropriate Infection Preventionist.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 882	Continued From page 28 individuals with training in infection prevention and control employed or contracted on a full time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2;or b. A Physician who has completed an infectious Disease fellowship; or c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of Infection Control experience. NJAC 8.39-20.2	F 882		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	406001	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

(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) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS 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.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews, and facility document review, the facility failed to ensure staffing ratios were met for 3 of 14 day shifts checked out of 42 total shifts reviewed. There was no substantial increase in the resident census for a period of forty-two consecutive shifts. This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated)	S 560	1. The Administrator and Director of Nurses will continue to utilize all possible means to increase the facility staff. This will include continued timely interviews, job fairs, setting up booths at nursing schools utilization of all possible avenues to increase staffing in the facility. 2. All residents have the potential to be affected by this deficient practice when staffing regulations are not met. 3. The Administrator, Director of Nurses and Director of Staffing were in-serviced by the Corporate Consultant on 11/29/2021 in regards to the new	3/31/22

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

Electronically Signed | 03/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	406001	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

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S 560	Continued From page 1 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the overnight shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The facility was deficient in CNA staffing for residents on 4 of 14 day shifts (weekend shifts) as follows: - 02/13/22 had 11 CNAs for 118 residents on the day shift, required 15 CNAs. - 02/19/22 had 14 CNAs for 116 residents on the day shift, required 15 CNAs. - 02/20/22 had 13 CNAs for 116 residents on the day shift, required 15 CNAs. - 02/26/22 had 11 CNAs for 120 residents on the day shift, required 15 CNAs. On 3/8/22 at 11:00 AM, the surveyor discussed the staffing ratios concerns with the Administrator, Director of Nursing, and VP of Clinical Compliance, who stated that the facility is attempting to hire new CNAs. NJAC 8:39-5.1(a)	S 560	minimum staffing requirements. All resumes will be reviewed within 24 hours of receipt. All on-line recruiting avenues will be accessed daily by the staffing Director ongoing 4. The Administrator and Director of Nursing will review daily the staffing levels with the staffing director. Findings will be reported at Qapi for the next three months.	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	406001	A. BUILDING: _____ B. WING _____	03/08/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

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STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
406001		5/23/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/31/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/8/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315465 Y1	A. Building B. Wing Y2	5/23/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0578	Correction	ID Prefix	F0658	Correction	ID Prefix	F0689	Correction
Reg. #	483.10(c)(6)(8)(g)(12)(i)-(v)	Completed	Reg. #	483.21(b)(3)(i)	Completed	Reg. #	483.25(d)(1)(2)	Completed
LSC		03/31/2022	LSC		05/12/2022	LSC		03/31/2022
ID Prefix	F0695	Correction	ID Prefix	F0711	Correction	ID Prefix	F0812	Correction
Reg. #	483.25(i)	Completed	Reg. #	483.30(b)(1)-(3)	Completed	Reg. #	483.60(i)(1)(2)	Completed
LSC		03/31/2022	LSC		03/31/2022	LSC		03/31/2022
ID Prefix	F0882	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.80(b)(1)-(4)(c)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		03/31/2022	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
3/8/2022	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315465	A. Building 01 - MAIN BUILDING 01 B. Wing	5/23/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW NURSING HOME	3200 HUDSON AVENUE UNION CITY, NJ 07087

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 04/05/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/8/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO