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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 000	INITIAL COMMENTS Facility Reportable Incident #: #166148 and #170244 Survey Date: 5/07/2024 to 5/17/2024 Census: 120 Sample: 24 + 3 closed records 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 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: NJ #170244	F 610	F610 INVESTIGATE/	5/31/24

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

Electronically Signed | 05/31/2024

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F 610	Continued From page 1 Based on observation, interview, and review of medical records, and other facility documentation, it was determined that the facility failed to timely and thoroughly investigate allegations of NJ Ex Order 2 for one (1) of two (2) residents (Resident #46) NJ ex order 26.4b1. This deficient practice was evidenced by the following: On 5/07/24 at 10:19 AM, the surveyor observed the resident had a visitor who was discussing leaving the facility for a few minutes. The surveyor observed the resident lying in bed, NJ Ex Order 26 head of the bed was elevated, and was NJ Ex Order 26.4(b)(1) At 10:53 AM, the resident informed the surveyor that a nurse [name redacted] NJ ex order 26.4b1 him/her. The resident narrated the following: NJ ex orde " The Resident recalled the nurse said to him/her NJ ex order 26.4b1 The surveyor reviewed the medical records of Resident #46. According to the Admission Record (or face sheet; an admission summary) reflected that the resident had been admitted with diagnoses which NJ ex order 26.4b1 Resident #46' s most recent quarterly Minimum	F 610	PREVENT/CORRECT ALLEGED VIOLATION • 1. RESIDENT #46 NJ ex order 26.4b1 . • 2. All residents who report allegations of abuse have the potential to be affected by the deficient practice. - A review was done of all reported allegations of abuse to ensure late thorough investigations were completed • 3. The policy and procedure “abuse prevention” was reviewed and updated • Nursing staff were reeducated on thorough and timely reporting investigation, including but not limited to: • The names of any person involved in the alleged incident • The person conducting the investigation will “interview all witnesses and staff in the immediate area. • Witness reports will be in writing. Witnesses will be required to sign and date such reports. All such reports will be attached to the “Abuse Investigation Report”. 4. The administrator or designee will review all abuse allegations reportable for the next 2 months, to ensure thorough and timely investigations were completed, the results of those audits will be reported to the Qapi committee for 2 months.	

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F 610	Continued From page 2	F 610		

Data Set (qMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated the resident NJ ex order 26.4b1. Additionally, the qMDS revealed that the resident NJ ex order 26.4b1 [redacted].

Review of Resident 46's Care Plan (CP), initiated on [redacted] and most recently reviewed on [redacted], included the resident NJ ex order 26.4b1 [redacted]

Review of the reportable event record/report (FRE; Facility Reported Event) reflected that it was called in by the facility on [redacted] at 4:35 PM to the state agency. Under "today's date" reflected [redacted], and an "event date" of [redacted] at 8:00 PM. NJ ex order 26.4b1 [redacted]. The event was described as follows: Resident #46 reported that a Nurse NJ ex order 26.4b1 at him/her. The report indicated that there were no planned interventions prior to the event. After the event, Resident #46 was assessed, was noted NJ ex order 26.4b1 [redacted] staff were interviewed, the resident was encouraged to NJ ex order 26.4b1 [redacted] to appropriate staff, physician, family, and ombudsman were made aware. "The nurse was immediately removed."

Review of the nursing assignment sheets reflected there were two (2) Licensed Practical Nurse (LPN) and four (4) Certified Nursing

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 610		F 610		

Continued From page 3

Assistant (CNA) and 1 U.S. FOIA (b) (6) assigned to Resident #46's floor.

Review of the undated/unsigned "Investigative Summary" (IS) included that the investigation involved medical records, care plan, staff interviews and NJ Ex Order 26.4(b) monitoring. The conclusion reflected that the resident became NJ Ex Order 26.4(b)(NJ Ex Order 26.4(b)(when the nurse tried to assist with and NJ Ex Order 26.4(b)(1). The report reflected resident had behaviors of NJ Ex Order 2 , at times. The resident assessed by the nursing staff and was found to NJ Ex Order 26.4(b)(1), and had no NJ Ex Order 26.4(b)(1), the NJ Ex Order 26.4(b)(1) did not reveal NJ Ex Order 26.4(b)

Attached to the IS was a written statement dated NJ ex order 26.4b1 by CNA #1 assigned to the resident revealed that the CNA #1 did not see the incident, and that there were no reports of the incidents made to her by the resident.

Another attachment to the IS report was a written statement dated NJ ex order 26.4b1 by CNA #2 that reflected she did not see anything or hear NJ Ex Order 26.4(b)(1) about the nurse.

The third attachment included was an undated typed statement from the US FOIA (b)(6) that showed that at around 8:00 PM the resident NJ Ex Order 26.4(b)(1) after NJ Ex Order 26.4(b)(1) the Licensed Practical Nurse (LPN #1) whose last name was not included in the statement. The LPN went to the front desk to get the food and was told money was required. The resident NJ ex order 26.4b1 . The [town

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F 610		F 610		

Continued From page 4

redacted NJ ex order 26.4b1 [redacted]

The [town redacted] NJ Ex report, the Resident statement, the alleged LPN #1 perpetrator, LPN #2, CNA #3, and CNA #4's statements were not included in the IS report.

Upon further review, the IS report did not identify the full name of the alleged US FOIA (B perpetrator, the status of the US FOIA (B after investigation in relation to Resident #46, US FOIA certification, license number, status, date of expiration, criminal background, reference check, most recent education on behavioral health, and abuse prevention.

On 5/09/24 at 11:57 AM, in the presence of the survey team, th US FOIA (B) (6) [redacted] US FOIA (B) (6) [redacted], and the US FOIA (B) (6) [redacted], the surveyor discussed the concern regarding the issues on the time of the facility reported event, the missing statement of the resident and alleged LPN #1. The missing perpetrator's full name, license information, reference, criminal background check as part of the investigation that was conducted by the facility.

On 5/14/27 at 11:22 AM, in the presence of the survey team, the US FOIA (B) (6) the US FOIA (B), the US FOIA (B), and the US FOIA (B) (6) [redacted], the US FOIA (B stated that the "facility called date on NJ ex order 26.4b at 4:35 PM" must have been a typographical error.

At that time, the US FOIA (B stated that she did not think she had to include the alleged LPN #1's name in

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F 610	Continued From page 5	F 610		

the report. The [redacted] acknowledged it should have been included within the submission.

At that time, the [redacted] stated that she had not conducted a review of the background check for LPN #1 because they had concluded the allegation was unsubstantiated.

At that time, the [redacted] stated that LPN #1 was an agency nurse and education was provided but could not state why the education for behavior and abuse prevention was not maintained on the file.

At that time, the [redacted] stated that a statement from LPN #1 was obtained but could not locate the document.

A review of the provided policy and procedure: Abuse Prevention dated/initiated May 2008 included the following:
Reporting and Investigation Protocols
-All phases of the investigation will be kept confidential in accordance with the facilities policy governing and confidentiality of medical records. Notices to regulatory agencies will include at the minimum:
"The name(s) of any person(s) involved in the alleged incident.
-The person conducting the investigation will:
"Interview all witnesses and staff in the immediate area.
-Witness reports will be in writing. Witness will be required to sign and date such reports. All such reports will be attached to the "Abuse Investigation Report".
-If a behavioral symptom begins suddenly or gets worse quickly, the following guidelines should be implemented at the time that the behavior occurs:

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F 610	Continued From page 6 No further information was provided.	F 610		
F 623 SS=D	NJAC-8.39-4.1(a)5, 13.4(c), 27.1 (a) Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		5/31/24

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F 623	Continued From page 7	F 623		

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the

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F 623	Continued From page 8 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide the resident and/or the resident's representative written notification of the reason for transfer to the hospital for two (2) of two (2) resident's (Resident #93 and #97) reviewed for hospitalization. This deficient practice was evidenced by the following: 1. A review of Resident #93's electronic medical record included the following: Resident #93's discharge assessment-return anticipated Minimum Data Set's (DRAMDS), an	F 623	F623 The following corrective actions were taken for the above deficiency 1.Resident # 93 and # 97 were sent a written notification for the reason of transfer to the hospital. 2. All discharged residents have the potential to be affected by the deficient practice of not receiving notification for the reason of discharge. 3. US FOIA (b)(6) was in serviced on the regulation that requires all discharged residents to receiving written notification as for the reason of discharge. 4. Administrator or his designee will audit	

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	315465	A. BUILDING _____ B. WING _____	C 05/17/2024

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F 623	Continued From page 9 assessment tool used to facilitate the management of care, dated NJ ex order 26.4b1, reflected that the resident was transferred to the hospital. A review of Resident #93's hybrid (a combination of paper, scanned, and computer-generated records) medical record did not include a written notification of the reason for transfer to the resident or resident representative for each transfer to the hospital. 2. A review of Resident #97's closed medical record included the following: Resident #97's DRAMDS dated NJ ex order 26.4 and NJ ex order 26.4, reflected that the resident was transferred to the hospital. A review of Resident #97's hybrid medical record did not include a written notification of the reason for transfer to the resident or resident representative for each transfer to the hospital. On 5/08/24 at 12:55 PM, the surveyor interviewed the US FOIA (B) (6) regarding written notification of the reason for transfer. The US FOIA (B) (6) stated that the facility did not send written notification to the resident or resident representative when the resident was transferred to the hospital. She added that the facility did send out a notice to the ombudsman that was faxed every month. On 5/09/24 at 12:22 PM, in the presence of the survey team, the surveyor notified the US FOIA (B) (6) US FOIA (B) (6), US FOIA (B) (6) US FOIA (B) (6) the concern that the	F 623	all discharges ensuring they receive notification weekly for two months, thereafter monthly for four months, findings will be reported to the Qapi committee on a quarterly basis for six months.	

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F 623	Continued From page 10 residents and/or their representatives did not have written notification of the reason they were transferred to the hospital. On 5/14/24 at 11:51 AM, in the presence of the survey team, US FOIA (B), US FOIA (B) (6) [redacted] US FOIA (B) the US FOIA (B) stated that he educated the US FOIA (B) in regard to the written notification and that the residents should have had the written notification for each transfer to the hospital. A review of the facility provided policy titled, "Transfer/Discharge Notification" with a last reviewed date of 02-2024, included the following: Protocol 1. Transfers and discharges include the movement of a resident/patient to a bed outside of the certified section whether that bed is in the same physical plant or not ... 3. Transfers and discharges will be conducted according to State and Federal regulations. Procedure 1. Provide the resident/patient with the "Bed Hold and In-House Transfer Policy" form as follows: At the time of admission At the time of transfer ... 4. Inform the resident/patient, legal representative, and family member of the right of appeal. N.J.A.C. 8:39-4.1(a)31,32	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		5/31/24

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 625	Continued From page 11 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, review of the medical record and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for two (2) of two (2) resident's (Resident #93 and #97) reviewed for hospitalizations. This deficient practice is evidenced by the following:	F 625	F625 The following corrective actions were taken for the above deficiency 1. Resident #93 and #97 were given a facility bed hold policy 2. All discharged residents have the potential to be affected by the deficient practice of not receiving the facility bed hold policy. 3. US FOIA (B) (6) was in serviced on the regulation that requires all discharged	

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	315465	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 625	Continued From page 12 1. A review of Resident #93's electronic medical record included the following: Resident #93's discharge assessment-return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, dated [NJ ex order 26.4] and [NJ ex order 26.4], reflected that the resident was transferred to the hospital. A review of Resident #93's hybrid (a combination of paper, scanned, and computer-generated records) medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative prior to each transfer to the hospital. 2. A review of Resident #97's closed medical record included the following: Resident #97's DRAMDS dated [NJ ex order 26.4] and [NJ ex order 26.4], reflected that the resident was transferred to the hospital. A review of Resident #97's hybrid medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative prior to each transfer to the hospital. On 5/08/24 at 01:05 PM, the surveyor interviewed the [US FOIA (b)(6)] regarding bed hold policy notification. The [US FO] stated that residents received the bed hold policy on admission and that she did not send out a written notification at time of transfer to the hospital. She added that the residents know that they have a ten day hold and that the facility always accepted them back even if it was past ten days.	F 625	residents to receive written notification of the facility bed hold policy. 4. Administrator or his designee will audit all discharges ensuring they receive notification of facility bed hold policy weekly for two months, thereafter monthly for four months, findings will be reported to the Qapi committee on a quarterly basis for six months.	

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 _____	C 05/17/2024

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F 625	Continued From page 13	F 625		

On 5/09/24 at 12:22 PM, in the presence of the survey team, the surveyor notified the U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted] and U.S. FOIA (b) (6) [redacted]) the concern that the residents and/or their representatives did not have written notification of the bed hold policy when they were transferred to the hospital.

On 5/14/24 at 11:51 AM, in the presence of the survey team, U.S. FOIA (b) (6) [redacted], U.S. FOIA (b) (6) [redacted]), U.S. FOIA (b) [redacted] and U.S. FOIA (b) (6) [redacted], the U.S. FOIA (b) [redacted] stated that he educated the U.S. FOIA [redacted] in regard to the written notification of the bed hold policy and that the residents should have had the written notification for each transfer to the hospital.

A review of the facility provided policy titled, "Bed Hold Notice Upon Transfer" with a last reviewed date of 02-2024, included the following:
Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy ....

A review of the facility provided policy titled, "Bed Hold and In-House Transfer" with a last reviewed date of 02-2024, included the following:
Protocol
1. A written notification of bed hold and in-house transfer policy form will be given to the resident/patient and his/her family member/legal representative upon admission.
2. A written notification (signed and dated by the resident/patient and family member) must be given to the resident/patient and family member

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 _____	C 05/17/2024

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F 625	Continued From page 14 each time of transfer for hospitalization or therapeutic leave. 3. The bed hold and in-house transfer policy form to be completed and issued as instructed on the document ... A review of the facility provided policy titled, "Transfer/Discharge Notification" with a last reviewed date of 02-2024, included the following: Protocol 1. Transfers and discharges include the movement of a resident/patient to a bed outside of the certified section whether that bed is in the same physical plant or not ... 3. Transfers and discharges will be conducted according to State and Federal regulations. Procedure 1. Provide the resident/patient with the "Bed Hold and In-House Transfer Policy" form as follows: At the time of admission At the time of transfer ... 4. Inform the resident/patient, legal representative, and family member of the right of appeal. N.J.A.C. 8:39-5.1 (a); 5.2 (a)	F 625		
F 640 SS=C	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.	F 640		5/31/24

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 640	Continued From page 15	F 640		

(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 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.

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 _____	C 05/17/2024

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F 640	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on the interview and review of pertinent facility documents, it was determined that the facility failed to complete the discharge Minimum Data Set (MDS) assessment, an assessment tool, as required for one (1) of one (1) system selected for the resident with an MDS record over NJ Ex O days reviewed (Resident #107). This deficient practice was evidenced by the following: On 5/08/24 at 12:13 PM, the surveyor reviewed the system-generated Resident Assessment Task and showed that Resident # 107 was identified as the resident's MDS record over NJ Ex O days old. The surveyor reviewed the medical records of Resident #107 as follows: According to the Admission Record (admission summary), Resident #107 was admitted to the facility with a diagnosis that included but was not limited to NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b) (NJ Ex O , NJ Ex Order 26.4(b)(1) , NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ ex Order 26.4b1 On 5/14/24 at 8:41 AM, the surveyor interviewed the US FOIA (B) (6) regarding the MDS in the presence of the US FOIA (B) (6) The US FOIA (B) (6)	F 640	0640 The following corrective actions were taken for the above deficiency 1. Resident #107 Mds was sent to the cms system 2. All residents have the potential to be affected by this deficient practice 3. US FOIA (B) (6) was inserviced on ensuring all Mds are summitted according the the regulation. Additionally she was taught how to check to see which mds are due. $. Regional director of Mds or her designee will audit Mds submissions twice a month for six months. Findings will be reported to the quarterly qapi meeting for six months.	

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 640	Continued From page 17	F 640		

stated that she was "not sure" when the discharge return not anticipated (DRNA) MDS should be transmitted after completing the assessment.

At that same time, the surveyor notified the US FOIA (B) (6) of the concern that Resident #107's NJ ex Order 26.4b1 which was NJ ex days after completing the assessment. The US FOIA (B) (6) stated that she missed it which was why the NJ ex Order 26.4b1 was completed and transmitted late. In addition, the MDSC/LPN acknowledged that the NJ ex Order 26.4b1

Furthermore, the US FOIA (B) (6) further stated that the facility followed the RAI (Resident Assessment Instrument, helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan) manual for MDS and there was no other policy on how to do MDS.

On 5/14/24 at 11:22 AM, the survey team met with the US FOIA (B) (6) US FOIA (B), US FOIA (B) (6), US FOIA (B) (6) and the US FOIA (B) (6) The surveyor notified the facility management of the above findings.

On 5/16/24 at 10:42 AM, the US FOIA (B) (6) in the presence of the US FOIA (B) (6) provided a copy of the MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act-required discharge assessments that include DRNA that must be completed) Assessment Report for the following dates:

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 _____	C 05/17/2024

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F 640	Continued From page 18	F 640		

NJ ex order 26.4b1 [redacted]

On that same date and time, the surveyor asked the facility management, if the facility was doing monthly ran of missing reports, why there was no report for NJ ex order 26.4b1. The U.S. FOIA (b) (6) stated that she was unable to find the copy for NJ ex order 26.4b1 that she ran the report for missing MDS. She further stated that "otherwise there was no excuse that MDS was late."

According to the CMS' (Centers for Medicare & Medicaid Services) RAI Version 3.0 Manual dated October 2019 that was provided by the U.S. FOIA (b) (6) regarding the transmittal requirements, it included that, 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 DRNA.

A review of the facility's RAI Process Policy that was provided by the U.S. FOIA with the last reviewed date of 02/2024 included the purpose to ensure that the MDS for each resident is completed accurately and timely in accordance with State and Federal regulations.

A review of the facility's Completion of MDS Policy that was provided by the U.S. FOIA with the last reviewed date of 02/2024 did not include and specify when to complete and transmit the MDS.

On 5/17/24 at 10:51 AM, the surveyors met with the US FOIA (B) (6) [redacted], and

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 _____	C 05/17/2024

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F 640	Continued From page 19 US FOIA (B) (6) for Exit Conference and the facility management did not provide additional information. NJAC 8:39- 11.1	F 640		
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: Based on interview, review of medical records, and other facility documentation, it was determined that the facility failed to adhere to acceptable standards of nursing practice in regards to the documentation of a resident's NJ Ex Order 26.4(b)(1) This deficient practice was identified for one (1) of three (3) residents (Resident #126) reviewed for closed records and 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 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 regimes as prescribed by a licensed or otherwise legally authorized physician or dentist."	F 658	F658 Services Provided Meet Professional Standards • 1. Resident 126 NJ ex order 26.4b1 in the facility, no further actions could be taken. • 2. Any resident who expired in the facility has the potential to be affected by this deficient practice. • An audit will be completed of medical records that expired in the facility in the past 2 months to ensure proper documentation was completed. • 3. nurses were re-educated on the “nurses Notes policy” with special focus on the documentation required at the time of resident’s expiration. This will include patient assessment time of death physician notification family notification and disposition of the body. • 4. DON/designee will review the medical records of all residents who expired in the facility for the next two	5/31/24

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 658	Continued From page 20 Reference: New Jersey Statutes, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey state: "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." The surveyor reviewed the medical record for Resident #126: A review of the Admission Record face sheet (an admission summary) reflected that Resident #126 was admitted to the facility with diagnosis that included, but not limited to, NJ Ex Order 26.4(b)(1) [redacted] and NJ Ex Order 26.4(b)(1) [redacted]. A review of the electronic medical record (eMR) Nursing Progress Notes included a note dated [redacted] at 6:18 PM that indicated, "[4:50 PM] Spoke with [...] regarding ETA of pick up. Will call back to inform. NJ ex order 26.4b1 [redacted]. NJ ex order 26.4b1 [redacted] [5:39 PM...] called to notify of pick up window 45 min to one hour. responsible party [...] notified of ETA (estimated time of arrival) of pick up. Family will NJ Ex Order 26.4(b)(1). Belongings gathered for family. [5:55 PM] Resident picked up by [...] NJ ex order 26.4b1 [redacted] [...] NJ ex order 26.4b1	F 658	months to ensure all necessary documentation is completed. the results of those audits will be reported to the Qapi committee for 2 months.	

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 658	Continued From page 21 NJ ex order 26.4b1 " There was no documentation of a change in the resident's clinical condition, including patient condition, vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a resident's essential body functions), along with NJ Ex Order 26.4(b)(1), physician notification, and family notification. On 5/16/24 at 12:03 PM, the surveyor interviewed the US FOIA (B) (6) in the presence of the US FOIA (B) (6) who confirmed that the required documentation for a resident's NJ Ex Order included the NJ Ex Order 26.4(b)(1), change in condition assessment, physician notification, and family notification. The US FOIA (B) acknowledged that the resident's NJ Ex Order 26 NJ Ex Order was important information for the electronic registration system. The US FOIA (B) further stated that all documentation should be entered "as soon as it happens." At that same time, the US FOIA (B) confirmed that, "the nurse documented the NJ Ex Order 26.4(b)(1) but not the NJ Ex Order 26.4(b)(1)." When asked if there was further information that should have been documented the US FOIA (B) responded, the time the physician was made aware, if the family was at bedside, and change of condition. At the end of the interview, the US FOIA (B) inquired if the nurse could submit a late entry. On 5/17/23 at 10:06 AM, the surveyors met with the US FOIA (B) in the presence of the US FOIA (B), US FOIA (B) (6) US FOIA (B) (6), and US FOIA (B) (6), the facility management acknowledged that, based on the electronic	F 658		

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 22	F 658		

medical record, the resident's NJ ex order 26.4b1 [redacted]

A review of the facility's "Nurse's Notes" policy, last reviewed 2/24, included:...Nurse's notes upon expiration should include: date, time of death, physician notification, death pronouncement by physician or RN, family notification and visitation, disposition of eyeglasses, dentures, valuables, personal belongings, and medications. Name and location of mortician or funeral home, post-mortem care given to resident, religious rites performed, if applicable release of body...

A review of the facility's "Death of a Resident/Patient " policy last reviewed 12/2023, included: Assess the resident/patient for vital signs: apical pulse; respirations; blood pressure...Call the physician and report your assessment of absence of vitals signs. Write the pronouncement and release as a telephone order...Notify the resident/patient's family, guardian, and/or representative...Document the following in the nurse's notes: time of absence of vital signs as determined; time and name of physician notified; time and name of family member notified; name of designated funeral home and time notified; name of the funeral home representative and time body released; status of deceased resident/patient personal possessions and what was sent with the body (i.e.: glasses, dentures, etc.

A review of the facility's undated "Job Description and Performance Standards" included: to assess resident treatment needs and take appropriate action and to maintain resident's medical records.

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	315465	A. BUILDING _____ B. WING _____	C 05/17/2024

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F 658	Continued From page 23 NJAC 8:39-11.2(b)	F 658		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		5/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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
F 732	Continued From page 24 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily. This failure could affect the knowledge of the availability of staff to care for the 120 residents, their family members, or their representatives. This deficient practice was evidenced by the following: On 5/07/24 at 8:35 AM, the surveyors entered the facility (on a Tuesday) and observed that the Nursing Home Resident Care Staffing Report (NHRCSR) posted in the front lobby was dated 5/02/24 (Thursday). The census (total number of residents) that was posted on 5/02/24 NHRCSR was 120. A review of the facility submitted Nurse Staffing Report for the week of 4/28/24 to 5/04/24 that was provided by the U.S. FOIA (b) (6)) showed that the census on 5/02/24 was 119. Further review of the above revealed that the census posted on 5/02/24 NHRCSR in the front lobby did not match the submitted Nurse Staffing Report. On 5/09/24 at 11:56 AM, the survey team met with the US FOIA (B) (6) , US FOIA (B) (6) and US FOIA (B) The surveyor notified the	F 732	F732 The following corrective actions were taken for the above deficiency 1. The public staffing information was corrected to reflect the accurate date, census, and number of hours worked by Rn, Lpn, and Cna. 2. Not having accurate staffing information does not allow the public and residents to accurately know the staffing ratios of the facility. 3. U.S. FOIA (b) (6) was in serviced on the regulation. All supervisors were in serviced and on the regulation and on their responsibility to update the public staffing data when staffing coordinator is not in the building. 4. Administrator or his designee will audit public staffing information postings weekly for two months, thereafter monthly for four months, findings will be reported to the Qapi committee on a quarterly basis for six months.	

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 732	Continued From page 25	F 732		

facility management of the findings regarding the inaccurate posting of the NHRCSR on 5/07/24.

On 5/14/24 at 11:22 AM, the survey team met with the US FOIA (B) (6), US FOIA (B) (6) US FOIA (B) (6) and US FOIA (B) (6). The US FOIA (B) stated that the NHRCSR should be posted daily at 8 AM. The US FOIA (B) stated and clarified that the NHRCSR should be accurate, updated, and posted at the beginning of each shift.

On 5/16/24 at 8:31 AM, the surveyor interviewed the US FOIA (B) (6) and US FOIA (B) (6). The US FOIA (B) (6) informed the surveyor that she was responsible for posting the NHRCSR in the front lobby of the facility. The US FOIA (B) (6) stated that she prepares the NHRCSR Monday through Friday and makes sure that it is posted before 8 AM. She further stated that she prepares the NHRCSR in advance for weekends and it is the responsibility of the weekend supervisor to correct if there will be changes in the census. She also stated that the NHRCSR should be updated at the beginning of each shift.

On that same date and time, the surveyor notified the US FOIA (B) (6) of the above findings and concerns. The US FOIA (B) (6) had no response as to why the posted NHRCSR on 5/07/24 was not accurate. Later on, the US FOIA (B) (6) stated that the posted NHRCSR should have been updated and accurate.

A review of the facility's Nurse Staff Posting Information Policy with a reviewed date of 11/2023 that was provided by the US FOIA (B) included that it is the policy of the facility to have sufficient staff to provide nursing services to attain or

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 732	Continued From page 26 maintain the highest practicable physical, mental and psychosocial well-being of each resident. The nurse staffing information will contain the following information: facility name, the current date, the facility's current census, and the total number and actual hours worked by the RN, Licensed Practical Nurses, and Certified Nurse Aides. On 5/17/24 at 10:51 AM, the surveyors met with the US FOIA (B) (6) and US FOIA (B) (6) for Exit Conference and the facility management did not provide additional information.	F 732		
F 742 SS=E	N.J.A.C. 8:39-41.2 (a)(b)(c)(d) Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Reference F-756 Based on observation, interview, record review, and review of other pertinent facility documentation it was determined that the facility failed to ensure a resident with history of	F 742	F742 Treatment/Services Mental/ Psychosocial Concerns. 1. Resident # 80 NJ ex order 26.4b1 . NJ ex order 26.4b1 .	5/31/24

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 742	Continued From page 27 NJ ex order 26.4b1 received appropriate treatment and services to attain the highest practicable NJ Ex Order 26 and NJ Ex Order 26.4(b)(1) . This deficient practice was identified for one (1) of five (5) residents (Resident #80) reviewed for unnecessary medications and was evidenced by the following: Reference: 13:44G-3.3 PRACTICE AS A CSW; SCOPE c) A CSW shall not engage in clinical social work services. 13:44G-1.2 DEFINITIONS "Clinical social work" means the professional application of social work methods and values in the assessment and psychotherapeutic counseling of individuals, families, or psychotherapy group. On 5/07/24 at 11:05 AM, during the initial tour, the surveyor observed Resident #80 resting on the bed, in NJ Ex Order 26.4(b)(1) with a NJ ex order 26.4b1 NJ ex order 26.4b1 The resident NJ Ex Order 26.4(b)(1)]. At that time, the U.S. FOIA (b) (6)) NJ Ex Order 26.4(b)(1 for the resident. The resident stated he/she NJ ex order 26.4b1 . On 5/09/24 at 11:23 AM, during an interview with the surveyor, the US FOIA (B) (6) stated she was a US FOIA (B) (6) The US FOIA (stated her responsibilities included scheduling meetings for the residents, their family, and the Interdisciplinary team to discuss the patient centered care.	F 742	2. All residents with documented psychiatric or trauma-related diagnoses on their PASRR have the potential to be affected by this deficient practice. Social services conducted an audit for all positive Level one PASRR everyone in the facility. To ensure all psychiatric or trauma-related diagnoses have been addressed. 3. U.S. FOIA (b) (6) and nursing department were re-educated on the care plan and trauma care-informed policy, and special focus was included to identify any special services recommended on the PASRR, As well as trauma-specific interventions that may be needed. 4. DON/designee will review PASRR level one (or 2) to ensure that all recommendations for specialized services for trauma-related interventions are addressed and placed on the care plan. the results of those audits will be reported to the Qapi committee for 2 months.	

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 742	Continued From page 28	F 742		

On 5/13/24 at 10:19 AM, the surveyor entered the room, observed the resident NJ Ex Order 26.4(b)(1) and [redacted] conducted in NJ Ex Order 26.4(b)(1)

At that time, the surveyor also observed the US FOIA (B) (6) standing across the room.

At that time, the [redacted] stated he was assigned to [redacted] the resident. The [redacted] stated he was a [redacted] and could not describe the reason for the NJ ex order 26.4b1.

On 5/13/24 at 10:20 AM, Resident #80 and the [redacted] were observed walking the hallway into the dayroom where activities were being held.

The surveyor reviewed the hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical records of Resident #80.

According to the resident's Admission Record (AR, or face sheet, an admission summary) reflected that resident NJ ex order 26.4b1 and had diagnoses [redacted]

Further review of the above AR, [redacted] was not listed.

A review of Resident #80's most recent quarterly Minimum Data Set (qMDS), an assessment tool

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 742	Continued From page 29	F 742		

used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] out of 15, which indicated that Resident #80's [redacted]

Further review of the qMDS section I-Active Diagnoses under [redacted] reflected [redacted] and [redacted]). [redacted] was not marked.

A review of the Pre-Admission Screening and Resident Review (PASRR) level 1 Screen, a screening tool that must be completed for all applicants to a nursing facility (NF), prior to admission included the following:
Under Section 2 - [redacted]

According to the PASRR Level 2 Determination Notification Form, it was determined that the resident had [redacted] treatment needs that can be met in the NF.
The following recommendation were made:
1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. Routine [redacted]
6. Formulate and implement a [redacted] to address any [redacted]
7. provide education to client and family on [redacted] and [redacted]
8. Develop a [redacted] Plan with

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 742	Continued From page 30	F 742		

the client

A review of Resident 80's Care Plan (CP; person centered plan) did not include a focus for [redacted].

A review of the electronic Medical Record (eMR) under Miscellaneous NJ ex order 26.4b1 [redacted].

A review of the Social Services Progress Notes (PN) did not reflect documentation that [redacted] services was provided in relation to [redacted].

A review of the electronic Medical Record under PN where the US FOIA (B) (6) documented a brief note that a "Report" would be provided to the facility. The PN did not reveal a monthly Medication Regimen Review (MRR) for [redacted]. The [redacted] reflected a late entry that was created on [redacted] by the [redacted].

A review of the [redacted] Report did not reflect an MRR for NJ ex order 26.4b1.

A review of the initial NJ ex order 26.4b1 from the previous provider dated [redacted], did not reflect NJ ex order 26.4b1.

A review of the initial and subsequent [redacted] with the new provider dated [redacted], NJ ex order 26.4b1 did not reflect that the provider identified, determined the underlying cause, developed, implemented approaches such as determining the target [redacted] and NJ Ex Order 26.4(b)(1) interventions to address the resident's [redacted].

A review of the Monthly [redacted] Summary

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 742		F 742		

Continued From page 31

([redacted] Monitoring Summary) for [redacted], [redacted], [redacted], [redacted] and the current [redacted], did not show identified [redacted] associated intervention for [redacted]

On 5/14/24 at 9:56 AM, during an interview with the surveyor, the U.S. FOIA (b) (6) [redacted] informed the surveyor that the company she had worked for had taken over the facility for [redacted] services less than a year ago. The [redacted] stated she had conducted an initial evaluation of the resident on [redacted], and only had three total visits.

At that time, the [redacted] confirmed she had not addressed the [redacted] on the resident's NJ ex order 26.4b1 even though it was identified as part of the Resident #80's chief complaint.

At that time, the [redacted] stated that the resident did not appear to need [redacted] and acknowledged that ruling out the need was not documented on the three previously conducted visits.

At that time, the surveyor had asked the [redacted] if target behaviors and NJ Ex Order 26.4(b)(1) interventions were part of the diagnosis and plan. The [redacted] stated that it was nothing that she had placed on the note.

On 5/14/24 at 12:13 PM, in the presence of the survey team, the US FOIA (B) (6) [redacted] the US FOIA (B) (6) [redacted] the US FOIA (B) (6) [redacted],

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 742	Continued From page 32	F 742		

the US FOIA (B) (6)) and the NJ Ex Order 26.4(B [redacted] the surveyor discussed the concern regarding the failure to provide services that included development of an individualized care plan, monitor and provide ongoing assessment of Resident #80's NJ ex order 26.4b1 [redacted].

On 5/16/24 at 12:40 PM, in the presence of the survey team, the US FOIA (B) (6), the US FOIA (B) [redacted], the US FOIA (B) (6) and the US FOIA (B) [redacted] the US FOIA (B) [redacted] stated, regarding Resident #80 and NJ ex order 26.4b1 [redacted] The DON also stated that US FOIA (B) (6)) NJ ex order 26 [redacted] Resident #80 for NJ ex order 26 [redacted].

At that time, the US FOIA (B [redacted] acknowledged that the resident NJ ex order 26.4b1 [redacted]

On 5/16/24 at 02:35 PM, the US FOIA (B [redacted] had informed the surveyor that Resident #80 NJ ex order 26.4b1 [redacted]

A review of the facility policy provided, Care Plan dated/revised 01/2024, included the following:
Policy: It is the policy of [facility name redacted] that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner.
Procedure:
1. Baseline Care Plans for all new admission will be initiated within 48 hours of admission
2. They will include goals, MD (Medical Doctor) orders, medications, treatments, dietary orders, therapy orders, social services and PASARR [PASRR] recommendations.
4. If PASARR [PASRR]recommends any special

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 742	Continued From page 33 services for specialized rehabilitation services, it will be included in the care plan. If the facility disagrees with the findings of the PASSAR [PASRR] it will indicate its rationale in the residence medical record A review of the facility policy provided; Trauma Informed Care dated/reviewed 2/2024 included the following: Purpose: 3. The Level 1 PASARR Screen will be reviewed upon admission as well as upon any newly diagnosed mental illness and/or intellectual disability/ developmental disability. The recommendations from the PASARR Level 2 determination will assist in the completion of the resident's assessment, care planning and transition care. 10. Trauma specific interventions for a resident will be placed in their individualized person-centered care plan upon admission and assessment ... 11. The facility will evaluate the progress of the trauma informed program by reviewing quarterly the changes in behavior of our residents who have been identified as having traumatic experiences during our multidisciplinary care plan and other 1-1 meeings.	F 742		
F 755 SS=E	NJAC 8:39-27.1 (a), 28.1 (c) 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	F 755		5/31/24

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 755	Continued From page 34	F 755		

them under an agreement described in §483.70(g). 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-

§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 interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) to consistently maintain accurate reconciliation, accountability of dispensed, and administered NJ Ex Order 26.4(b)(1) NJ ex order 26.4b1 for Resident #16, b.) ensure expired NJ Ex Order 26.4 medications were detected, removed, and disposed from active inventory which was

F755/ Pharmacy Services/Procedures/Pharmacist/Records

- 1. Resident #16 NJ ex order 26.4b1 NJ ex order 26.4b1
- 2. The matter of the cycle count not

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 755	Continued From page 35 stored within the electronic back-up machine (EBM). The deficient practice was identified for one (1) of one (1) of the EBM observed during medication storage inspection. The evidence was as follows: 1.) On 5/08/24 at 8:57 AM, during an interview with the surveyor, the US FOIA (B) (6) stated that she conducted the NJ Ex Order 26.4 reconciliation (cycle counts) daily with a nurse supervisor or with the U.S. FOIA (b) (6)). The US FOIA (B also stated she received a daily report of the NJ ex order 26.4b1 which detailed which the inventory on-hand, the nurse who removed the NJ ex order 26.4b and for which resident. At that time, the surveyor requested for the daily transaction inventory report of the EBM. The surveyor reviewed the medical record for Resident #16. According to the resident's Admission Record (or face sheet, an admission summary) reflected that that resident was a NJ Ex Order 26.4(b)(1)) resident at the facility and had diagnoses which NJ ex order 26.4b1 Resident #16's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated NJ ex order 26.4b, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of NJ ex out of 15, which indicated that Resident #16's NJ ex order 26.4b1 On 5/08/24 at 10:46 AM, the US FOIA (B informed the	F 755	being performed daily did not result in any dose discrepancy within the electronic backup machine. Any resident receiving narcotic medication from the backup machine in the facility has the potential to be affected by these deficient practices. • No resident was administered any expired medication. • Unit managers conducted an audit immediately to ensure all residents with narcotics orders had their medication available in their med carts. • A pharmacy representative was contacted to provide a trash run of all narcotics medication dispensed from the electronic so that a reconciliation be completed, and no other discrepancies were identified. All expired medications identified in the electronic backup machine were removed and replaced. • 3. Nurses were re-educated on the policy for automatic dispensing as well as the policy for medication storage. • Nurses were re-educated on checking the expiration date prior to removing from the backup machine. Nurses were re-educated that any medication removed from the backup machine must match exactly the order given by the physician. a manual daily cycle count was put in place and is completed by the 11-7 nursing supervisor. • 4. DON/designee will monitor 5 narcotics doses removed from the electronic backup machine weekly for 2 months to ensure that the dose removed matches the order written by the physician. • DON/ Designee will audit the	

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 755	Continued From page 36 surveyor that the pharmacy provider was having issues with the report, and she had not received the daily report from the pharmacy [via electronic mail]. The facility did not keep a paper log of the EBM inventory. At that time, the US FOIA (B stated that she did not work seven days a week and there were no tracking or reconciliation of the NJ Ex Order 26.4 medications (meds) within the EBM on the weekend that she was off. On 5/08/23 at 11:03 AM, while waiting for the pharmacy provider inventory report, the US FOIA (B stated that there were no super users (staff that can remove a NJ Ex Order 26.4 med from the EBM without a witness) in the facility. On 5/08/24 at 12:25 PM, the surveyor and the US FOIA (B reviewed the EBM report for Transactions by Employee from NJ ex order 26.4b1. The report did not reflect a daily reconciliation of all the NJ Ex Order 26.4 meds daily. At that time, the U.S. FOIA (confirmed that the NJ Ex Order 26.4(b) were not reconciled daily. On 5/08/24 at 01:11 PM, in the presence of the U.S. FOIA (b) and the US FOIA (B, the surveyor reviewed another facility provided report; Transaction log by department (TLD). The report showed the inventory for the NJ ex order 26.4b1 , was NJ ex order 26.4b1 the inventory on hand NJ ex order 26.4b1 . Further review of the TLD did not reflect the witnesses' names when the NJ ex order 26.4b1	F 755	electronic once a week for 2 months to ensure that there are no expired medications. • DON/ DESIGNEE will review the manual cycle count log 2 times a week for 2 months to ensure cycle count is being completed, the results of those audits will be reported to the Qapi committee for 2 months.	

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 _____	C 05/17/2024

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F 755		F 755		

Continued From page 37

At that time, in the presence of the [US FOIA (B)] and the [US FOIA (B)], the surveyor discussed the concerns regarding the missing witnesses name and the declining inventory count of the [NJ ex order 26.4b1] without transactions in between.

On 5/09/24 at 11:57 AM, in the presence of the survey team, the [US FOIA (B) (6)] [US FOIA (B) (6)] [US FOIA (B) (6)], and the [US FOIA (B)], the surveyor discussed the concern regarding the facility's failure to consistently maintain accurate reconciliation, accountability of dispensed, and administered [NJ Ex Order 26.4] meds.

On 5/09/24 at 12:49 PM, the [US FOIA (B)] provided the surveyor a third report, the [NJ Ex Order 26.4(b)(1)] by Container Report ([NJ Ex Order 26.]. A review of the [NJ Ex Order 2] report reflected the witnesses' names, enumerated transaction by date/time with the declining inventory count of the [NJ ex order 26.4b1].

Further review of the [NJ Ex Order 26.4(b)(1)] reflected the following:
-On [NJ ex order 26.4] at 12:34 PM, the [US FOIA (B)] removed two (2) tabs, for Resident #16 with witnessed by [US FOIA] #1
-On [NJ ex order 26.4] at 6:54 PM, the [US FOIA (B)] removed two (2) tabs for Resident #16, witnessed by LPN #2
-On [NJ ex order 26.4] at 8:35 AM, the [US FOIA (B)] removed [NJ ex] [NJ ex ord] for Resident #16, witnessed by LPN #3
-On [NJ ex order 26.4] at 9:27 PM, the [US FOIA (B) (6)] removed [NJ ex order 2] for Resident #16, without a witness
-On [NJ ex order 26.4] at 10:03 PM, the [US FOIA (B)] [NJ ex order 26.4b1] [NJ ex ord] back name into the EBM utilizing Resident #16's name, without a witness

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 755	Continued From page 38	F 755		

-On [redacted] at 10:15 AM, the [redacted] for Resident #16, witnessed by LPN #4
-On [redacted] at 9:49 PM, RN/S removed [redacted] for Resident #16 without a witness
-On [redacted] at 9:09 AM, LPN #1 removed [redacted] for Resident #16 witnessed by [redacted]

The [redacted] revealed that the facility had a staff that did not require a witness to remove a narcotic med.

A review of the Order Summary Report (OSR) for [redacted] reflected an order for [redacted],
[redacted]

The OSR did not reveal an order for [redacted]

The electronic Medication Administration Record (eMAR) did not reflect administration of the [redacted] on the following dates and time:
1. [redacted] at 6:54 PM
2. [redacted] at 8:35 AM
3. [redacted] at 10:15 AM
4. [redacted] at 9:49 PM
5. [redacted] at 9:09 AM

On 5/09/24 at 01:48 PM, the surveyor discussed with the [redacted] the concern regarding the inconsistent accounting, dispensing, and administration of the [redacted] the concern involved eight (8) nursing staff.

At that time, the [redacted] acknowledged that a med should not be administered without a physician's

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 755	Continued From page 39	F 755		

order.

At that time, the [US FOIA (B)] stated she was not aware that a facility staff was granted access to the [NJ Ex Order 26.4] EBM machine in which a witness was not required. The [US FOIA (B)] also stated that a nurse should have not had this type of access.

At that time, the [US FOIA (B)] confirmed that she was not aware that the NJ ex order 26.4b1 [redacted].

At that time, the [US FOIA (B)] could not explain how the facility process for accountability and reconciliation missed identification of the removal of the NJ ex order 26.4b1 in a span of four (4) days.

On 5/14/27 at 11:22 AM, in the presence of the survey team, the [US FOIA (B) (6)], the [US FOIA (B)], the [US FOIA (B) (6)] and the [US FOIA (B)], the [US FOIA (B)] stated a new process was placed to easily track the on-hand and reconciliation of the [NJ Ex Order 26.4(b)] in the EBM. The [US FOIA (B)] acknowledged that a physician' order was required prior to administration of a med. The [US FOIA (B)] acknowledged all the concerns and stated education was provided to the nursing staff.

2.) On 5/09/24 at 01:35 PM, during the observation of the cycle count for the EBM, by the [US FOIA (B)] and the [NJ Ex Order 26.4], the surveyor observed the following expired [NJ Ex Order 26.4(b)] meds in the EBM:

-NJ ex order 26.4b1 [redacted]

-NJ ex order 26.4b1 [redacted]

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 40 -NJ ex order 26.4b1 On that same date and time, the US FOIA (B and the NJ Ex Order 2 confirmed they also observed the expired meds. At that same time, the US FOIA (B stated she was unable to remove the expired NJ Ex Order 26.4(b) from the active inventory stored in the EBM until she received a letter from the NJ Ex Order 26.4(b)(1) . Furthermore, the US FOIA (B stated that the nurses would have to look at the expiration date prior to removing a med from the active inventory in the EBM. In addition, the surveyor asked the U.S. FOIA (b), should an expired narcotic med be intermingled with the active inventory that was stored in the EBM. The U.S. FOIA (b) stated that the correct protocol would be to remove the expired NJ Ex Order 26.4 from the active inventory to avoid med administration error. At that time, the US FOIA (B acknowledged that the expired NJ Ex Order 26.4 should have been removed from the active inventory. On 5/14/27 at 11:22 AM, in the presence of the survey team, the US FOIA (B) (6), the US FOIA (B), the US FOIA (B), and the US FOIA (B) (6) the US FOIA (B acknowledged the concerns and stated that education was provided to the nursing staff. A review of the provided facility policy; Medication Storage dated/revised 9/6/2019, included the following: Policy:	F 755		

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 _____	C 05/17/2024

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F 755	Continued From page 41 Meds will be stored in a manner that maintains the integrity of the product ensures the safety of the residents and is on accordance with NJ Department of Health guidelines. Procedure F. Expired, discontinues and/or contaminated meds will be removed from the med storage area and disposed of in accordance with facility policy. A review of the undated facility policy; Loss or Theft of Drugs included under Policy; Any theft or loss of drugs must be reported immediately to facility management and appropriate actions taken. A review of the facility policy provided, ADS [Automatic Dispensing System] Station Med Policies and Procedures, effective date of 10/01/2018 included the following: Policy: Nursing and Pharmacy will use the ADS Station as an inventory, charging, and information system for the control and distribution of meds for Emergency, First-Dose use and other situations where meds are not available from the pharmacy. (Not to be used for continuous dosing). NJAC 8:39-11.2(b), 27.1(1), 29.2(a,d), 29.4 (g), 29.7(c)	F 755		
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		5/31/24

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 42 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and a review of pertinent facility documents, it was determined that the facility failed to a.) provide oversight by a licensed U.S. FOIA (b) (6) in NJ Ex Order 2 for four (4) of five (5) residents, (Residents #17, #49, #75, and #80) and the entire month of NJ Ex Order 26.4(b)(1), for five (5) of five (5) residents, (Residents #17, #22, #49, #75, and #80), b.)	F 756	f756 Drug Regimen Review, Report Irregular, • 1. Residents #17, #49, #75, #80, and #22 suffer no ill effect from this deficient practice. The U.S. FOIA (b) (6) was contacted and a retracted review was conducted to ensure no medication	

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	315465	A. BUILDING _____ B. WING _____	C 05/17/2024

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F 756	Continued From page 43 identify the irregularity with regard to physician's order for NJ ex order 26.4b1 for one (1) of five (5) residents, (Resident #22) NJ ex order 26.4b1 in accordance to facility's practice and policy. This deficient practice was evidenced by the following: 1. On 5/07/24 at 11:16 AM, the surveyor observed Resident #22 in the dayroom. The surveyor reviewed Resident #22's hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical record (HMR). According to the Admission Record (AR, an admission summary), the resident was admitted to the facility with diagnoses that included but were NJ ex order 26.4b1 NJ ex order 26.4b1 A review of the NJ ex order 26.4b1 Order Summary Report (OSR) included a physician's order (PO) dated NJ ex order 26.4b of NJ ex order 26.4b1 .	F 756	irregularities existed for these five residents. • 2. All residents receiving medications in the month of NJ ex order 26.4b1 had the potential to be affected by the deficient practice. Retroactive review was conducted by the pharmacy consultant and was done and no significant irregularities were noted. • 3. Nurses were re-educated on addressing dosing recommendations that appear in the medication record when medication orders are entered. • The US FOIA (6 was educated on the Medication Regimen Review Policy with a focus on ensuring that the provider pharmacy consultant submits a monthly review for each resident. • The DON created a monthly tracking log to ensure that each resident receives a monthly medication review before the end of each month. • 4. The DON/designee will review electronic medical records for 5 residents per week for 2 months with new medication orders to ensure any noted dosing recommendation has been addressed. • The administrator will review the medication regimen tracking log monthly for the next 2 months to ensure a timely medication regimen review for each resident. the results of those audits will be reported to the Qapi committee for 2 months.	

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	315465	A. BUILDING _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 756	Continued From page 44	F 756		

The above order for [redacted] was transcribed and signed by nurses as administered from [redacted], and from [redacted]

A review of the Progress Notes (PN) created on [redacted] at 02:51 PM by the [redacted] included that the order for [redacted] give [redacted] by mouth at HS [redacted] the [redacted]

Further review of the PN revealed that there was no Pharmacy Consultant Note (PCN) for [redacted]. There was a late entry PCN dated [redacted] that included "Medications were reviewed. Report provided."

A review of the CP monthly Medication Regimen Review (MRR) binder that was provided by the [redacted] showed that there was no report for [redacted] and [redacted].

On 5/09/24 at 10:50 AM, the surveyor asked the [redacted] why CP's review for [redacted] was not in the blue binders that the [redacted] had provided for the surveyor to review. The [redacted] stated that the facility "had not received the CP's review yet." The surveyor then asked the [redacted] for the CP's phone number and she said that she will get back to the surveyor.

On 5/09/24 at 11:07 AM, the surveyor interviewed Consultant Pharmacist #1 (CP#1). CP#1 informed the surveyor that she was covering CP. CP#1 stated that the assigned CP, CP#2 [redacted] and unable to respond to the surveyor's inquiry which was why CP#1 was the one who

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 756	Continued From page 45	F 756		

called back.

On that same date and time, CP#1 informed the surveyor that CP#3, the regular CP of the facility left in early NJ ex order 26.4b1 and CP#2 was the designated CP then. CP#1 stated that there was a NJ ex order 26.4b1 MRR review by CP#2 for the 3rd floor but was unable to find or state if the 4th and 5th floor reviews were done. She further stated that there were no MRR reviews for NJ ex order 26.4b1 for the 3rd, 4th, and 5th floors. CP#1 also stated that she would do the reviews and put it as a late entry after the surveyor's inquiry. She indicated that the NJ ex order 26.4b1 MRR was still to be done. She acknowledged that MRR for all residents should have been done monthly as required by the facility and regulations.

On 5/09/24 at 11:56 AM, the survey team met with the US FOIA (B) (6) , US FOIA (B) (6) US FOIA (B) , and the US FOIA (B) . The surveyor notified the facility management of the above concerns and findings.

On 5/09/24 at 01:45 PM, the US FOIA (B) provided a copy of the printed CP's MRR for the date NJ ex order 26.4b1 for the 3rd floor residents which included Resident #22. The NJ ex order 26.4b1 MRR did not include recommendations or notes that the irregularity for the NJ ex order 26.4b1 was identified for Resident #22. There were no NJ ex order 26.4b1 MRR for the 4th and 5th floors.

A review of the facility's Medication Regimen Review Policy with a created date of NJ ex order 26.4b1 that was provided by the US FOIA (B) included that it is the facility policy to provide an MRR for all residents

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 756	Continued From page 46	F 756		

admitted to the nursing facility. MRR is a thorough evaluation of the medication (med) regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences associated with med. The review includes preventing, identifying, reporting, and resolving medication-related problems, med errors, or other irregularities, and collaborating with other members of the interdisciplinary team. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

On 5/14/24 at 11:22 AM, the survey team met with the [redacted], and [redacted]. The [redacted] stated and acknowledged that there was no [redacted] MRR for the 4th and 5th floors and for the whole of [redacted] for the 3rd, 4th, and 5th floors according to the facility's practice, policy, and regulations. The [redacted] further stated that the facility was unaware of the reason why there was no MRR done in [redacted] and [redacted] not until the surveyor's inquiry. The [redacted] also stated that it was her responsibility to make sure that the MRR was done timely by the CP.

At that same time, the [redacted] informed the surveyor that the resident received the right dose of NJ ex order 26.4b1 [redacted] even though the NJ ex order 26.4b1 [redacted].

2. On [redacted] at 10:29 AM, the surveyor observed Resident #17 asleep in his/her bed.

The surveyor reviewed Resident #17's HMR.

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 756	Continued From page 47	F 756		

The AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to NJ ex order 26.4b1 [redacted]

Resident #17's PCN revealed that the last MRR was on NJ ex order 26.4b1

Further review of Resident #17's hybrid MR showed that there were no MRRs for NJ ex order 26.4b1 and NJ ex order 26.4b1.

On 5/14/24 at 12:16 PM, in the presence of the survey team, the surveyor notified the US FOIA (B), US FOIA (B) (6) and US FOIA (B) (6) the concern that Resident #17 did not have a MRR done after NJ ex order 26.4b1

On 5/15/24 at 12:53 PM, the DON confirmed that Resident #17 NJ ex order 26.4b1 [redacted]

The facility did not provide any additional information.

3. On 5/07/24 at 11:02 AM, during the initial tour, the surveyor observed Resident #49 asleep with the head of the bed elevated. The resident was covered with a blanket.

The surveyor reviewed the HMR of Resident #49.

The AR reflected that that resident was a NJ ex order 26.4b1 resident at the facility and had diagnoses which NJ ex order 26.4b1

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 756	Continued From page 48	F 756		

NJ ex order 26.4b1 [redacted]

A review of the PCN where the CP documented a brief note that a "Report" would be provided to the facility. The PN did not reveal an MRR for [redacted]. The NJ ex order 26.4b1 reflected a late entry that was created on [redacted] by the CP.

A review of the CP Report did not reflect an MRR for [redacted] and NJ ex order 26.4b1

4. On 5/07/24 at 9:46 AM, the surveyor observed Resident #75 walking up and down the low side of the hallway while using a [redacted]. The resident was pleasant and spoke in [language redacted].

The surveyor reviewed the HMR of Resident #75.

The AR reflected that that resident was a [redacted] at the facility and had diagnoses which NJ ex order 26.4b1 [redacted].

A review of the PCN where the CP documented a brief note that a "Report" would be provided to the facility. The PN did not reveal an MRR for [redacted] NJ ex order 26.4b1

A review of the CP Report did not reflect an MRR

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 _____	C 05/17/2024

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F 756	Continued From page 49 for NJ ex order 26.4b1. 4. On 5/07/24 at 11:05 AM, during the initial tour the surveyor observed Resident #80 resting on the bed, in NJ Ex Order 26.4(b)(1) with a NJ ex order 26.4b1 [redacted] The resident spoke [language redacted]. The surveyor reviewed the HMR of Resident #80. The AR reflected that that resident was a NJ ex orde NJ ex order 26.4b at the facility and had diagnoses which NJ ex order 26.4b1 [redacted]. A review of the PCN where the CP documented a brief note that a "Report" would be provided to the facility. The PN did not reveal an MRR for NJ ex order 26 NJ ex orde. The NJ ex order 26.4b1 reflected a late entry that was created on NJ ex order 26.4b by the CP. A review of the CP Report did not reflect an MRR for NJ ex order 26.4b1. NJAC 8:39-29.3 (a)(1)	F 756		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		5/31/24

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 50 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: REPEAT DEFICIENCY Based on observation, interview, and review of documentation provided by the facility, it was determined that the facility failed to a) maintain proper kitchen sanitation practices and clean equipment, b) properly store foods in a safe manner to prevent the development of food borne illness, and c) maintain three (3) of three (3) nursing unit pantry used for residents in a sanitary manner. This deficient practice was evidenced by the following: On 5/07/24 at 10:16 AM, the surveyor toured the kitchen in the presence of the US FOIA (B) (6) [redacted], the US FOIA (B) (6) and the US FOIA (B) (6)), and observed the following: ~In the walk-in freezer, several boxes of opened food items that were opened, unlabeled and exposed to freezer with freezer burn and frost on them. Those items were as follows: chicken	F 812	1. a) The identified items in the walk-in freezer were disposed of. b) Uncovered trash can was removed from the food preparation area. c) Both steam tables were cleaned thoroughly. d) 3rd and 4th floor ice machines were shut down and thoroughly cleaned. e) New ice scoopers were purchased and the old ones were disposed of. f) 4th floor pantry sink had the old caulk removed and was recalked. 2. All residents have the potential to be affected by the deficient practice of not properly labeling and dating food, by not properly cleaning and sanitizing the steam tables, ice machines, pantry sink, and by not keeping the preparation area in the kitchen unexposed to garbage and the like. 3. a) The kitchen staff was immediately in	

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 812	Continued From page 51 tenders, salisbury beef steaks, opened loose corn, and pizza. All listed items were opened, unsealed, unlabeled with open date or expiration dates. The U.S. FOIA (b) (6) was unable to say when the packages were opened. ~The food preparation area had a trash can filled with garbage and food debris that was uncovered. ~Two (2) steamer tables with three (3) sections each totaling six (6), was noted to have opaque water with sediment at the bottom which the US FOIA was able to scoop up and it was determined it was rice and that had not been used this day for a meal. The US FOIA stated the table water was supposed to be cleaned between meals and daily. The US FOIA acknowledged that it had not been done per policy. On 5/07/24 at 10:30 AM, the surveyor interviewed the US FOIA (b) who stated that labeling of food was a requirement in his kitchen. The food should be labeled with expiration date and if opened it should be labeled with open date and the package should be resealed to keep the contents fresh. Labeling allows for first in first out concept which saves food integrity, prevents freezer burn, and waste production." She further stated, "The cooking equipment is on a cleaning schedule and the findings of the kitchen equipment (steamer table) should have all been cleaned and water changed." On 5/08/24 at 11:47 AM, the surveyor observed 3 of 3 pantry, one on each nursing unit (3rd, 4th and 5th floor). The purpose of the pantry was for residential use. Each pantry was equipped with a refrigerator, microwave, sink and ice machine.	F 812	serviced on properly dating and labeling food items, cleaning the steam tables after use, and not having uncovered garbage in the food preparation area. b) Housekeeping department and US FOIA (b)(6) was in serviced on making sure ice machine is cleaned properly, ice scooper is clean and not sitting in water, and the food pantry area is clean. 4. Administrator or his designee will audit food preparation area, all food is properly labeled and dated, kitchen is clean, all ice machines and ice scoopers are clean and residents' food preparation are properly weekly for two months, thereafter monthly for four months, findings will be reported to the Qapi committee on a quarterly basis for six months.	

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	315465	A. BUILDING _____ B. WING _____	C 05/17/2024

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F 812	Continued From page 52	F 812		

The surveyor observed in the presence of the U.S. FOIA (b) (6)), the pantry on the 3rd floor nursing unit had build-up of white sediment on the outer lip of the door flap that was wipeable. On the interior back panel where ice dispenses it had a yellowish film that was wipeable by the U.S. FOIA (b) (6) The 3rd floor pantry had a rectangular plastic bucket that the staff put the ice scoop in. The bottom had a build up of water and orange film in the interior corners that the scoop was sitting in.

On 5/08/24 at 12:10 PM, the U.S. FOIA (b) (6) acknowledged that the ice machine needed to be cleaned and the scoop should not be sitting in stagnant water. She also stated, "it should not be like this because the residents use this ice for their drinks, and it can cause an infection or make them sick."

On 5/08/24 at 12:28 PM, the surveyor observed in the presence of the U.S. FOIA (b) (6)) pantry on the 4th floor nursing unit had build-up of white sediment on the outer lip of the door flap that was wipeable. On the interior back panel where ice dispenses it had a yellowish/ orange film covering the whole panel and on the right side of the interior panel and in the hinge, flap was coated with black sediment. All were wipeable by the U.S. FOIA (b) (6).

On that same date and time, both the surveyor and the U.S. FOIA (b) (6) observed the 4th floor pantry had an ice scoop holder mounted to the wall behind the ice machine. The mounted holder was composed of two (2) separate pieces that attached to each other. Neither piece was equipped with drainage holes. The ice scoop was

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 53	F 812		

sitting in stagnant water and the bottom of the interior piece was coated with brown and black sediment. When the US FOIA (B) (6) removed the piece and placed in sink and filled it with water the sediment started to flake off. The scoop tip had cracks in the plastic that were discolored gray.

At that same time, the surveyor observed the 4th floor sink, which had black sediment around the sink, caulk, and backsplash areas.

On 5/08/24 at 12:55 PM, the US FOIA (B) (6) came to the 4th floor pantry. The surveyor observed in the presence of the US FOIA (B) (6) and US FOI the ice machine, scoop mount, scoop, and the sink, which had black sediment around the sink, caulk, and backsplash areas.

On 5/08/24 at 12:58 PM, the surveyor interviewed the US FOIA, he acknowledged that "it should be cleaned" and further stated, "I am shutting the unit down and having it cleaned right now." He further stated, "It should be cleaned daily." The surveyor reviewed the black sediment behind, on, and around the sink with the US FOIA and asked to see the US FOIA (B) (6). The US FOIA stated, "I am the US FOIA and the US FOIA in a dual capacity position." The US FOI acknowledged the sink area and stated, "he would have it cleaned and fixed." He further stated, "I would need to notify the US FOIA (B) (6)

On 5/08/24 at 01:03 PM the surveyor, in the presence of the US FOI toured the 5th floor pantry. The 5th floor pantry had an ice scoop holder mounted to the wall behind the ice machine. The mounted holder was composed of two (2) separate pieces that attached to each other.

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 54	F 812		

Neither piece was equipped with drainage holes. The ice scoop was sitting in stagnant water and the bottom of the interior piece was coated with brown and black sediment.

On 5/08/24 at 01:06 PM, the [redacted] acknowledged that the holder "should have drainage holes to prevent stagnant water buildup which can cause bacteria and mold."

On 5/09/24 at 10:34 AM, the surveyor interviewed the [redacted], who stated "I acknowledge the issues in the 3rd, 4th and 5th floor pantry." I was informed by my [redacted] and the [redacted]. The [redacted] further stated that the cleaning process was in place to prevent bacteria and possible illnesses that can happen. She also stated that it was everyone's responsibility to keep the units clean. In addition, the [redacted] stated that if a [redacted] sees something, they should report to the nurse, the [redacted], "or myself" to have it reported to the appropriate department to get fixed or cleaned. The [redacted] further stated that "the [redacted] should be doing audits on their floor to make sure items are cleaned and in working order according to policy."

On 5/09/24 at 12:42 PM, the surveyor interviewed the [redacted] who stated, "the reason to have a clean and unsoiled pantry is to prevent pest, rodents, and bacteria. It should be maintained and clean for the residents because this is their home. I will have to do more in-services on the cleaning process. I will set those up with the [redacted]."

A review of an updated Dining Services, Food Storage Policy, included:
Food items will be stored, thawed, and prepared

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 55	F 812		

in accordance with good sanitary practice.
Procedures:
All products shall be dated upon receipt or when they are prepared. Use date shall be marked on all food containers according to the timetable in dry, refrigerated and freezer storage chart found in this section.
Frozen Meat/ Poultry /and Foods:
Storage: Foods shall be stored in their original containers if designed for freezing. Foods to be frozen shall be stored in airtight containers or wrapped in heavy duty aluminum foil or special laminated papers. Labels and date all food items.

A review of the undated Labeling and Dating System Protocol Policy included:
~follow manufactures expiration date on all un-opened or opened products. If there is no printed date on the product, follow below dating protocol:
"All frozen foods allowed three days to defrost in cooler. Add those three days to the expiration date on the "open/prep and expiration" label.
"All food in freezer storage six months

A review of the undated Dining Services, Steam Table Policy which revealed:
1. It is the responsibility of ALL cooks to keep the steam table clean and sanitized every meal.
2. The morning cook will make sure that steam table wells are filled with adequate amount of water (clean) before turning it on.
3. The nighttime cook is responsible for always changing the water in each well and to refill each well with adequate amount of water.
4. The steam table must be turned off at night, filled with clean water and each well is covered.

A review of the undated Dining Services, Garbage

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 56 and Trash cans Policy which included: Sanitation of Equipment. All food waste must be placed in covered garbage and trash cans. A review of the Infection Control, Cleaning and Disinfecting Ice Machines and Ice Chest Policy, last revised dated 10/01/23, included: To minimize the potential for infection from proper cleaning and maintenance of ice machines and ice chests. The facility is committed to providing a safe and healthy environment for residents and to minimize or prevent the spread of infections. 2. Ice Scoops: "Surfaces of the scoop should be smooth and unbroken. If scoops are cracked or have irregular surfaces, they should be discarded and replaced. "Store the scoop in a container with drainage area at the bottom when not in use. "Do not rest the scoop in/on any other surface. 3. Ice Machines: "Disinfect the drop opening of the ice machine once a month with an appropriate disinfectant. A review of the undated Ice Machine Policy included: Sanitation of equipment: Frequency: Daily "Wash exertion of machine. Use sanitizing solution and clean cloth. A review of the Policy: Daily Pantry Room Cleaning, dated 01/2024, included: Steps to be done. 2. Dust all horizontal surfaces with a cloth and disinfectant, wipe all horizontal (flat) surfaces. 4. Spot Clean with a cloth and disinfectant spot clean all vertical surfaces. NJAC 8:39-17.2(g)	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2)	F 883		5/31/24

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 883	Continued From page 57 §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 (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	F 883		

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 883	Continued From page 58 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 observation, interview, and record review, it was determined that the facility failed to ensure each resident was offered NJ Ex Order 26.4(b)(1) [redacted] according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on NJ Ex Order 26.4(b)(1) Practices ([redacted] recommendations. This deficient practice was identified for two (2) of five (5) residents reviewed for NJ Ex Order 26.4(b)(1) status (Resident #75 and Resident 80). The deficient practice was evidenced by the following: Reference: A review of the CDC guidelines for Pneumococcal vaccination included: For adults 65 years and older who only received the Pneumococcal polysaccharide vaccine (Pneumovax/PPSV 23),"Give (1) dose of Pneumococcal conjugate vaccine (PCV 15 or PCV20) at least one year after the most recent PPSV23 vaccination."	F 883	F883 INFLUENZA AND PNUEMOCCOCAL IMMUNIZATIONS. • 1. Residents #75 and 80 NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] . Both residents [redacted] before the end of the survey. • 2. All residents who have not received the pneumococcal vaccine have the potential to be affected by this deficient practice. • The infection preventionist immediately conducted an audit to identify all other residents not vaccinated with the pneumococcal vaccine, those residents identified and or responsible parties were contacted to request consent to receive the vaccination. All Those that consented to receive the vaccine will be vaccinated.	

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 883	Continued From page 59 Reference: A review of the ACIP included: On October 21, 2021, the ACIP recommended use of 20-valent pneumococcal conjugate vaccine (PCV20 [Prevnar 20) alone or 15-valent pneumococcal conjugate vaccine (PCV15) in series with 23-valent pneumococcal polysaccharide vaccine (PPSV23) [Pneumovax23) for all adults aged 65 years. 1. The surveyor reviewed the hybrid (combination of paper and electronic) medical record (HMR) for Resident #75. According to the Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which NJ ex order 26.4b1 [redacted] Resident #75's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated [redacted], reflected that the resident NJ ex order 26.4b1 [redacted] Further review of the qMDS dated [redacted], under section [redacted] A. Was the resident's NJ Ex Order 26.4(b)(1) to date? The response was marked [redacted] which reflected [redacted]. Section B. [redacted] state reason: The response was blank for the following: not eligible, offered and declined and not offered. A review of the electronic Medication Administration Record (eMAR) under	F 883	• 3. The US FOIA (b)(6) was re-educated on the MOST CURRENT CDC guideline for pneumococcal vaccination. The facility's Pneumococcal policy was updated. • 4. DON/designee will audit the immunization of 3 residents per week for 2 months to ensure the vaccine has been offered, given, and/or declination documented. The result of this audit will be brought to the QAPI committed for the next two months.	

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 883	Continued From page 60	F 883		

Immunization indicated the resident received NJ ex order 26.4b1

A review of the paper chart NJ ex order 26.4b1 [redacted]

2. The surveyor reviewed the HMR for Resident 80.

The AR reflected that the resident was admitted to the facility with diagnoses which NJ ex order 26.4b1 [redacted]

Resident #80s most recent qMDS dated NJ ex order 26.4b1, reflected that the resident had a BIMS score of NJ ex out of 15, which indicated the resident's NJ ex order 26.4b1.

Further review of the qMDS dated NJ ex order 26.4b1, under section O0300 A. Was the resident's NJ ex order 26.4b1? The response was marked NJ ex which reflected NJ ex. Section B. If NJ ex order 26.4b1, state reason: The response was blank for the following: not eligible, offered and declined and not offered.

A review of the eMAR under Immunization indicated the resident received NJ ex order 26.4b1 [redacted]

A review of the paper chart did not reflect a record that NJ ex order 26.4b1 was offered to the resident.

On 5/13/24 at 11:34 AM, during an interview with the surveyor, the U.S. FOIA (b) (6)

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	3200 HUDSON AVENUE UNION CITY, NJ 07087

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F 883		F 883		

Continued From page 61

US FOIA (B) (6) stated that the facility and the facility policy followed the CDC guidelines of the NJ Ex Order 26.4(b)(1) schedule for adults. The U.S. FOIA (b) stated that the residents who were 65 years old and older received PPSV-23 unless contraindicated. The NJ Ex Order 2 informed the surveyor that she was not part of the team that reviewed the facility policy for the NJ Ex Order 26.4(b)(1).

On that same date and time, the surveyor notified the US FOIA (B) the concern regarding the NJ ex order 26.4b1 schedule for Resident # 75 and #80 that were not up to date, and the policy and procedure for NJ Ex Order 26.4(b)(1) that did not reflect the current CDC guideline.

On 5/13/24 at 12:34 PM, during a follow-up meeting with the surveyor, the US FOIA (B) stated that she had reviewed the current CDC guidelines, Resident #75 and #80's NJ ex order 26.4b1 NJ ex order 26.4b1 schedule. The U.S. FOIA (b) (C further stated that both residents should have received NJ ex order 26.4b one (1) year after receiving .

At that time, US FOIA (B) also stated she should have reviewed the resident's immunization schedule. The U.S. FOIA (b) stated she would call the prescriber to discuss the missing NJ ex order 26.4b1, discuss with the resident (when appropriate), discuss with the family, obtain a consent or refusal. She also stated she would conduct an audit of all the immunization. Lastly, the US FOIA (B) stated that she would meet with the US FOIA (B) (6) to discuss the current CDC guideline for NJ ex order 26.4b1.

On 5/14/24 at 12:13 PM, during a meeting with

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 883		F 883		

Continued From page 62

the survey team, the [US FOIA (B) (6)], the [US FOIA] Licensed [US FOIA (B) (6)]), the [US FOIA (B) (6)] and the [US FOIA (B)], the surveyor discussed the concern regarding the [NJ ex order 26.4b1] for Resident #75, #80 and the outdate policy.

On 5/14/27 at 12:37 PM, in the presence of two surveyors, the [US FOIA (B)] acknowledged that both residents [NJ ex order 26.4b1] [NJ ex order 26.4b1] as outlined by the current CDC and ACIP recommendations.

A review of the facility provided policy dated reviewed/revised on 02/2024 reflected under Policy: It is the policy of this facility that all residents will be evaluated at the time of admission for the appropriateness of receiving the Pneumonia Vaccine as per CDC Recommendations.

The Procedures included the following:
1. No more vax (vaccine) will be offered to all residents unless it is medically contraindicated, or the resident has already been immunized. There are two types of pneumococcal vaccines available in the country:
A. Pneumococcal conjugate vaccine (PCV12 or Prevanar 13)
B. Pneumococcal polysaccharide vaccine (PPSV23 Pneumovax 23)

N.J.A.C. 8:39-19.4(h), (i), (j)

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND H	3200 HUDSON AVENUE UNION CITY, NJ 07087

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S 000	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.	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: REPEAT DEFICIENCY Based on interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 14 of 14 day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	S560 1. There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements. Staffing coordinator was reeducated on the proper staffing guidelines as mandated by the state of New Jersey. 2. All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios. 3. The following measures have been put into place to prevent the deficient practice from recurring: a. Advertisement / Job postings for	5/31/24

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

Electronically Signed | 05/31/24

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 _____	C 05/17/2024

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MANHATTANVIEW CTR FOR REHABILITATION AND H	3200 HUDSON AVENUE UNION CITY, NJ 07087

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S 560	Continued From page 1 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 2/01/21: 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 night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested staffing for the following weeks: For the 2 weeks of staffing prior to the survey from 4/21/2024 to 5/04/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -04/21/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/22/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/23/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/24/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs. -04/25/24 had 12 CNAs for 122 residents on the day shift, required at least 15 CNAs. -04/26/24 had 12 CNAs for 121 residents on the	S 560	CNAs have been posted on social media websites as well as flyers posted in local supermarkets and stores that we are hiring. Offering generous sign on bonus for new hires. b. Incentives are offered to CNAs to work extra shifts such as gift cards and raffles. c. Administrator has reached out to CNA schools to advise we are hiring and willing to train new graduates. d. Contract has been signed with CNA school, and they have committed to having their students do their clinicals at the facility. e. Facility has agreed to sponsor work visas for the students of the class. f. Tables are being set up by job fairs letting people know that the facility is hiring CNAs. 4. The Administrator/Designee will review the staffing schedule weekly to monitor the staffing ratio on the day shift for 3 months. 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.	

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	406001	A. BUILDING: _____ B. WING _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND H	3200 HUDSON AVENUE UNION CITY, NJ 07087

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S 560	Continued From page 2	S 560		

day shift, required at least 15 CNAs.
-04/27/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs.

-04/28/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-04/29/24 had 12 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-04/30/24 had 13 CNAs for 121 residents on the day shift, required at least 15 CNAs.
-05/01/24 had 12 CNAs for 120 residents on the day shift, required at least 15 CNAs.
-05/02/24 had 12 CNAs for 119 residents on the day shift, required at least 15 CNAs.
-05/03/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs.
-05/04/24 had 12 CNAs for 118 residents on the day shift, required at least 15 CNAs.

On 5/16/24 at 8:31 AM, the surveyor interviewed the Human Resource/Business Office Manager (HR/BOM). The HR/BOM informed the surveyor that she was responsible for staffing for facility's nurses and CNAs. She claimed that she was aware of the NJ mandated staffing law for CNAs, which was 1 CNA to 10 residents for all shifts (7 AM-3 PM, 3 PM-11 PM, and 11 PM-7 AM). The HR/BOM stated that as per the facility's practice and policy, she was required to staff all three units/floors (3rd, 4th, and 5th floor) with 4 CNAs for 7-3 and 3-11 shifts, three CNAs at 3rd floor for 11-7 shift, and two CNAs at 4th and 5th floors for 11-7 shift.

On that same date and time, the surveyor asked the HR/BOM if she was meeting the requirement for NJ mandated staffing ratios and the facility's practice and policy for staffing, and she stated "yes."

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	406001	A. BUILDING: _____ B. WING _____	C 05/17/2024

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S 560	Continued From page 3 A review of the facility's Nursing Services and Sufficient Staff Policy that was provided by the Director of Nursing (DON) with a reviewed date of 7/2023 included that it is the policy of this facility to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity, and diagnoses of the resident population will be considered based on the facility assessment. A review of the Facility Assessment that was provided by the LNHA was revised on 7/2023 and included a Staffing Plan: in no event does the overall number of qualified staff provided to meet each resident's needs fall below the minimum daily average required by state law for direct care and services per resident day. On 5/17/24 at 8:36 AM The surveyor interviewed the Licensed Nursing Home Administrator (LNHA) regarding staffing. The LNHA stated that he was aware of the NJ mandated staffing ratio of 1 CNA to 8 residents for 7-3 shifts, 1 CNA to 10 residents for 3-11 shifts, and 1 CNA to 16 residents for 11-7 shifts. The LNHA further stated that "definitely the attempt to meet the goal considering the challenges, sometimes we cannot meet it," the mandated ratio "because we don't have enough staff." On 5/17/24 at 10:51 AM, the surveyors met with the LNHA, DON, Registered Nurse Vice President of Clinical Operations (RNVPoCO), VP of Operations (VPoO), Infection Preventionist/Registered Nurse, and VP of Clinical Compliance for the Exit Conference. The surveyor notified the facility management of the	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 4 above concerns regarding staffing. The facility management did not provide additional information.	S 560		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. 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 provide residents two evening activity programs per week. This deficient practice was identified for three (3) of three (3) months reviewed, March 2024, April 2024 and May 2024. This deficient practice was evidenced by the following: On 5/07/24 at 10:42 AM, the surveyor observed the facility's activity calendar which was posted on a bulletin board in the hallway of the fifth floor unit. The calendar did not have two evening activities per week scheduled on the calendar. The calendar had "relaxing time" for 5 PM scheduled each day. On 5/08/24 at 12:02 PM, the surveyor interviewed the Recreation Director (RD) regarding activities. The RD stated that the facility had one calendar for daily activities and one calendar for special events. He added that the large calendar had the	S 720	S720 The following corrective actions were taken for the above deficiency 1. Evening Activities two times a week was added immediately to schedule. 2. All residents have the potential to be affected by the deficient practice 3. Activities director was in serviced on the regulation on having evening activities 2 days a week. 4. The Administrator/Designee will review the activity schedule weekly for 3 months and report his findings to the Qapi committee for six months.	5/31/24

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND H	3200 HUDSON AVENUE UNION CITY, NJ 07087

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S 720	Continued From page 5	S 720		

daily activities and that the small one had the special events. The surveyor requested three months of both calendars.

The surveyor reviewed the calendars which reflected that the facility did not include two evening activities per week on the calendars.

On 5/08/24 at 12:17 PM, the surveyor interviewed the RD regarding evening activities. The RD confirmed that the last activity was relaxation time at 5 PM. He added that they tried to do small group activities when getting ready for dinner. The RD stated that the special events were held around 2 PM. He added that staff were scheduled until 6 PM but that during their last hour of work the staff were preparing residents for dinner. The RD confirmed that the facility did not have any scheduled activities in the evening.

On 5/09/24 at 11:57 AM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Vice President of Operations (VPoO) and Registered Nurse VP of Clinical Operations (RNVPoCO) the concern that the facility did not have any evening activities.

On 5/14/24 at 11:53 AM, in the presence of the survey team, DON, Infection Preventionist/Registered Nurse (IP/RN), VPoO and RNVPoCO, the LNHA stated that the facility immediately updated the calendar to include two evening activities each week.

A review of the facility provided policy, titled "Activities", dated 02/2024 included the following:
Procedure ...
3. Our activity programs consist of individual, small, and large group activities that are designed

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND H	3200 HUDSON AVENUE UNION CITY, NJ 07087

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S 720	Continued From page 6 to meet the needs and interests of each resident, offered several times a week, and include at minimum: ... At least two (2) evening activity is offered per week, depending on population needs.	S 720		
S1405	8:39-19.5(a) Mandatory Infection Control and Sanitation 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 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 REQUIREMENT is not met as evidenced by: Based on interviews and a review of the facility provided pertinent documentation, it was determined that the facility failed to ensure that five (5) of eight (8) newly hired employees (Staff #1, #2, #3, #4, and #5) had completed a [NJ Ex Order 2] [redacted] and received an [NJ Ex Order 26.4(b)(1)] by a	S1405	S1405 The following corrective actions were taken for the above deficiency 1. Staff # 1,2,3,4,5 had a new [NJ Ex Order 26.4(] done.	5/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND H	3200 HUDSON AVENUE UNION CITY, NJ 07087

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S1405	Continued From page 7 Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. This deficient practice was evidenced by the following: A review of the eight randomly selected newly hired employee files included the following: Staff #1, a non-certified Nursing Aide #1 (NA#1), hired on [redacted], had an [redacted] dated [redacted] Staff #2, NA#2, hired on [redacted], did not have an [redacted] in their file. Staff #3, NA#3, hired on [redacted] Staff #4, a Registered Nurse (RN), hired on [redacted] had an [redacted] Staff #5, a Licensed Practical Nurse (LPN), hired on [redacted], had an [redacted]. On 5/08/24 at 02:18 PM, the surveyor interviewed the Infection Preventionist Registered Nurse (IP/RN) in the presence of another surveyor. The surveyor notified the IP/RN of the above findings. On 5/09/24 at 11:56 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Vice President of Operations (VPoO), and RN VP of Clinical Operations (RNVPoCO). The surveyor notified the facility management of the above findings. On 5/14/24 at 11:22 AM, the survey team met	S1405	2. All residents have the potential to be affected by staff not having physicals per the regulation. 3. Human Resources director was in serviced on the regulation. An audit was done on employee files to ensure current employees have a physical as per the regulation. 4. The administrator or his designee will audit all new hires file for six months, findings will be reported to the quarterly Quality Assurance and Performance Improvement Committee committee for six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S1405	Continued From page 8 with the LNHA, DON, IP/RN, VPoO, and RNVPoCO. The facility management acknowledged that Staff #1, #2, and #3 newly hired employees failed to complete a [NJ Ex Order 2] [redacted] and received an [NJ Ex Order 26.4(b)(1)] by a Physician, an Advanced Practice Nurse, or a Licensed Physician Assistant within two weeks prior to employment or upon employment. On 5/14/24 at 01:37 PM, the surveyor interviewed the DON. The DON checked the employee files and acknowledged the above findings regarding Staff #4 and #5. The DON also verified and clarified the hire date of Staff #5 on [NJ ex order 26.4b1] [redacted] A review of the facility's Evaluation/Physicals Policy with a revised date of 5/2024 that was provided by the LNHA included that personnel will all be checked for baseline health assessment on hire, including immunization status. All new employees will complete a screening health history within two weeks of hire or within 30 days of hire if assessed by an RN upon hire. On 5/17/24 at 10:51 AM, the surveyors met with the LNHA, DON, RNVPoCO, VPoO, IP/RN, and VP of Clinical Compliance for the Exit Conference. The facility management did not provide additional information.	S1405		
S1410	8:39-19.5(b)(1) Mandatory Infection Control and Sanitation (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	S1410		5/31/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND H	3200 HUDSON AVENUE UNION CITY, NJ 07087

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S1410	Continued From page 9 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 REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documents, it was determined that the facility failed to perform a [NJ Ex Order 26.4(b)(1)] [redacted] as required for new employees hired for [NJ Ex Order 26.4(b)(1)] for infection and disease screening. This deficient practice was identified for one (1) of eight (8) employee files (Staff #1) reviewed. This deficient practice was evidenced by the following: A review of the eight randomly selected newly hired employee files included the following: Staff #1, a non-certified Nursing Aide #1 (NA#1), hired on [NJ ex order 26.4], had a [NJ ex order 26.4b1] that was done	S1410	S1410 The following corrective actions were taken for the above deficiency 1. Staff #1 NJ ex order 26.4b1 [redacted] 2. All residents have the potential to be affected by staff not being cleared of Tb as per the regulation. 3. Human Resources director was in serviced on ensuring all hires medical files allow hire to work as per regulation. 4. The administrator or his designee will audit all new hires file for six months, findings will be reported to the quarterly Quality Assurance and Performance Improvement Committee for six months.	

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND H	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
S1410	Continued From page 10 on [redacted] for clinical indication of a [redacted] There was no documentation when the [redacted] was done. The [redacted] The Infection Control/Employee Health Nurse signed the annual [redacted] Assessment on [redacted] with a handwritten note to see the [redacted] Further review of the employee records of Staff #1 revealed that there were no [redacted] results on file. On 5/08/24 at 02:18 PM, the surveyor interviewed the Infection Preventionist Registered Nurse (IP/RN) in the presence of another surveyor. The surveyor notified the IP/RN of the above findings. On 5/09/24 at 11:56 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Vice President of Operations (VPoO), and RN VP of Clinical Operations (RNVPoCO). The surveyor notified the facility management of the above findings. A review of the facility's Evaluation/Physicals Policy with a revised date of 5/2024 that was provided by the LNHA included that personnel will all be checked for baseline health assessment on hire, including immunization status. All new employees will receive a two-step Mantoux (PPD) testing upon hire unless they have documentation of a positive Mantoux history and/or a copy of a recent chest x-ray documenting negative active tuberculosis.	S1410		

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 _____	C 05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND H	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
S1410	Continued From page 11 On 5/17/24 at 10:51 AM, the surveyors met with the LNHA, DON, RNVPoCO, VPoO, IP/RN, and VP of Clinical Compliance for the Exit Conference. The facility management did not provide additional information.	S1410		

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 B. Wing	8/7/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 05/31/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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	
5/17/2024	☐ 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	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 F0610	Correction	ID Prefix F0623	Correction	ID Prefix F0625	Correction
Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.15(c)(3)-(6)(8)	Completed	Reg. # 483.15(d)(1)(2)	Completed
LSC	05/31/2024	LSC	05/31/2024	LSC	05/31/2024
ID Prefix F0640	Correction	ID Prefix F0658	Correction	ID Prefix F0732	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.35(g)(1)-(4)	Completed
LSC	05/31/2024	LSC	05/31/2024	LSC	05/31/2024
ID Prefix F0742	Correction	ID Prefix F0755	Correction	ID Prefix F0756	Correction
Reg. # 483.40(b)(1)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(c)(1)(2)(4)(5)	Completed
LSC	05/31/2024	LSC	05/31/2024	LSC	05/31/2024
ID Prefix F0812	Correction	ID Prefix F0883	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.80(d)(1)(2)	Completed	Reg. #	Completed
LSC	05/31/2024	LSC	05/31/2024	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?
5/17/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
406001 Y1	A. Building B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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 S0560	Correction	ID Prefix S0720	Correction	ID Prefix S1405	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. # 8:39-7.3(d)	Completed	Reg. # 8:39-19.5(a)	Completed
LSC	05/31/2024	LSC	05/31/2024	LSC	05/31/2024
ID Prefix S1410	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-19.5(b)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/31/2024	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	
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	
5/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING **01** B. WING _____	**05/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	**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
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 05/14/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 05/14/24 and was found to be in noncompliance 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. Manhattanview Center for Rehabilitation and Healthcare is a five-story building with a basement that was built in the 1950's. It is composed of Type II protected construction. The facility is divided into eight - smoke zones. The generator does approximately 50 % of the building per the Maintenance Director. The current occupied beds are 120 of 127.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily	K 345		6/30/24

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

Electronically Signed | 05/31/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING **01** B. WING _____	**05/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	**3200 HUDSON AVENUE** **UNION CITY, NJ 07087**

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K 345	Continued From page 1 available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure smoke detection sensitivity testing of the smoke detectors were completed every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 120 residents. Findings include: A review of the facility's "Inspection and Testing Reports," dated 03/12/24, provided by the US FOIA (b)(6), revealed the report had no reference to a smoke detection sensitivity test. Observations on 05/14/24 from 12:30 PM to 2:40 PM revealed the smoke detectors were in the resident rooms and other concealed areas throughout the building. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the smoke sensitivity testing had not been completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	K345 Fire alarm system 1. The sensitivity testing of the smoke detectors will be completed. Testing was completed. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the regulation of having a sensitivity testing of smoke detectors every alternate year. 4. Audit will be done by the maintenance director/designee annually to ensure the facility is up to date with the required smoke detector sensitivity testing. Audit findings will be shared with the QAPI committee annually.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING	K 372		7/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING **01** B. WING _____	**05/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	**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
K 372	Continued From page 2 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. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to ensure fire dampers in the smoke barrier walls were inspected every four-years in accordance with NFPA 80 Standard for Fire Doors and Other Opening Protectives (2010 edition) 19.4.1.1. This deficient practice had the potential to affect 120 residents. Findings include: Observations on 05/14/24 at 1:15 PM revealed the smoke barriers in the electrical room and generator room located in the basement were equipped with fire dampers. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed that there were no reports of the fire dampers being tested. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 372	K372 1. The fire dampers inspection will be completed. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the regulation of having the fire dampers inspected every four years. 4. Audit will be done by the maintenance director/designee annually to ensure the facility is up to date with the required fire damper inspection. Audit findings will be shared with the QAPI committee annually.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors	K 761		6/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING **01** B. WING _____	**05/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	**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
K 761	Continued From page 3 Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility failed to ensure fire doors were inspected annually by an individual who could demonstrate the knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 120 residents. Findings include: A review of the facility's untitled fire safety binder provided by the facility revealed no documented evidence that the facility's fire doors were inspected. Observations on 05/14/24 from 12:30 PM to 2:40 PM of the facility's fire doors revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. During an interview at the time of each observation, the U.S. FOIA (b) (6) confirmed	K 761	K761 1. Facility Fire doors were inspected. 2. All residents have the potential to be affected by this deficient practice. 3. The maintenance department was educated on the regulation of having the fire doors inspected every year 4. Audit will be done by the maintenance director/designee annually to ensure the facility is up to date with the required fire door inspections. Audit findings will be shared with the QAPI committee annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING **01** B. WING _____	**05/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	**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
K 761	Continued From page 4 the fire doors had not been inspected annually. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing 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	K 918		8/2/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. BUILDING **01** B. WING _____	**05/17/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	**3200 HUDSON AVENUE** **UNION CITY, NJ 07087**

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K 918	Continued From page 5 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure a load bank test was completed on the emergency generator once every 36 months in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 8.4.1. This deficient practice had the potential to affect all 120 residents. Findings include: A review of the facility's untitled generator reports dated for the years 2020, 2022, 2023 and 2024, provided by the facility revealed a three-year load bank test had not been completed for the emergency generator. During an interview on 05/14/24 at 2:40 PM the U.S. FOIA (b) (6) confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	K918 1. The load bank test for the emergency generator will be completed 2. All residents have the potential to be affected by this deficient practice. 3.The maintenance department was educated on the regulation of having a back load test done on the emergency generator every 36 months. 4. Audit will be done by the maintenance director/designee annually to ensure the facility is up to date with the required back load test. Audit findings will be shared with the QAPI committee annually	

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 01 - MAIN BUILDING 01 B. Wing Y2	8/7/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MANHATTANVIEW CTR FOR REHABILITATION AND HEALTHCAR	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		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0345	06/30/2024	LSC	K0372	07/29/2024	LSC	K0761	06/30/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0918	08/02/2024	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		
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	
5/17/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO