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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |  | (X5)<br>COMPLETION<br>DATE                      |  |
| F0000                                                                | <p>INITIAL COMMENTS</p> <p>Complaint #s NJ 172110</p> <p>STANDARD SURVEY: 7/25-7/31/25</p> <p>CENSUS: 265</p> <p>SAMPLE SIZE: 35+3 closed records</p> <p>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.</p>                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | F0000               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | 09/05/2025                                      |  |
| F0641<br>SS = D                                                      | <p>Accuracy of Assessments</p> <p>CFR(s): 483.20(g)(h)(i)(j)</p> <p>§483.20(g) Accuracy of Assessments.</p> <p>The assessment must accurately reflect the resident's status.</p> <p>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>§483.20(i) Certification.</p> <p>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.</p> <p>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>§483.20(j) Penalty for Falsification.</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a</p> |                                                                        | F0641               | <p>F0641 – ACCURACY OF ASSESSMENT</p> <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>Resident #220's assessment was immediately modified and submitted to accurately reflect that resident is receiving <b>NJ Exec Order 2</b></p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All dialysis residents have the potential to be affected.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the RESIDENT #220</p> <p>deficient practice does not reoccur?</p> <p>The VP of Clinical Reimbursement re-educated the <b>U.S. FOU</b> on Federal Regulation F641 related to accuracy of dialysis assessments coding.</p> |  | 09/05/2025                                      |  |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F0641<br>SS = D                                                      | <p>Continued from page 1<br/>resident assessment is subject to a civil money penalty<br/>of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material<br/>and false statement in a resident assessment is subject<br/>to a civil money penalty or not more than \$5,000 for<br/>each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute<br/>a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interviews and record review, it was<br/>determined that the facility failed to accurately code<br/>the Minimum Data Set (MDS, an assessment tool used to<br/>facilitate the management of care), in accordance with<br/>federal guidelines, for 2 of 35 residents (Resident<br/>#220 and #274), who were reviewed for accuracy for MDS<br/>coding.</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 07/28/25 at 10:45 AM, the surveyor observed<br/>Resident #220 in bed, awake, alert, who stated that<br/>they came back from [REDACTED] this morning and have been<br/>attending [REDACTED] NJ Exec Order 26.4b1<br/>[REDACTED] for [REDACTED] NJ Exec Order 26.4b1 years<br/>now.</p> <p>On 07/28/25 10:54 AM, the surveyor reviewed the hybrid<br/>medical record (paper and electronic) of Resident #220,<br/>which revealed the following:</p> <p>A review of the Admission Record (AR, an admission<br/>summary) reflected that Resident #220 was admitted with<br/>diagnoses that included, but were not limited to,<br/>[REDACTED] NJ Exec Order 26.4b1<br/>[REDACTED].</p> <p>A review of the annual Minimum Data Set (A/MDS), (an<br/>assessment tool used to facilitate the management of<br/>care), dated [REDACTED] NJ Exec Order 26.4b1, indicated that the facility<br/>assessed the residents' cognitive status using a Brief<br/>Interview for Mental Status (BIMS) score of [REDACTED] NJ Exec Order 26.4b1<br/>[REDACTED], which indicated that the resident had [REDACTED] NJ Exec Order 26.4b1<br/>[REDACTED] Further review of the A/MDS in Section [REDACTED] NJ Exec Order 26.4b1<br/>[REDACTED] stated [REDACTED] NJ Exec Order 26.4b1 while a resident – No.</p> | F0641                                                                  | <p>Continued from page 1</p> <p>How will the corrective action(s) be monitored to<br/>ensure the deficient practice will not reoccur and what<br/>QA program will be put into place?</p> <p>The Lead MDS Coordinator and/or designee will conduct<br/>audits on assessments of 2 dialysis residents/week x 4<br/>weeks, then 1 dialysis resident x 4 weeks, then<br/>1x/month x 4 months to ensure accuracy.</p> <p>Results of the audits will be reported to the Quality<br/>Assurance Committee.</p> <p>The QAPI Committee will make recommendations based upon<br/>the results of the audits.</p> <p>The QAPI Committee will recommend tapering and<br/>dissolution of audits once consistent compliance has<br/>been achieved.</p> <p>B. Resident #274</p> <p>1. What corrective action was accomplished for the<br/>resident found to have been affected by the deficient<br/>practice?</p> <p>The MDS Coordinator immediately modified and submitted<br/>the discharge assessment to accurately reflect that<br/>resident had a planned discharge.</p> <p>The MDS Coordinator reviewed the discharges from the<br/>last 30 days and no other unplanned coding error found.</p> <p>2. How will other residents who may have the potential<br/>to be affected be identified?</p> <p>All residents who will be discharged from the facility<br/>have the potential to be affected.</p> <p>3. What measures will be put into place or what<br/>systematic changes will be made to ensure that the<br/>deficient practice does not reoccur?</p> <p>The VP of Clinical Reimbursement re-educated the [REDACTED] NJ Exec Order 26.4b1<br/>[REDACTED] on Federal Regulation F641 related to<br/>accuracy of discharge assessments coding.</p> |                                                 |  |

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| F0641<br>SS = D                                                      | <p>Continued from page 2</p> <p>A review of the Order Summary Report (OSR) with a start date on [NJ Exec Order 26.4] revealed an order of [NJ Exec Order 26.4] at [facility name redacted] every [NJ Exec Order 26.4b1] [redacted]</p> <p>A review of the "Care Plan Report" with an initiated date of [NJ Exec Order 26.4], with the focus on [NJ Exec Order 26.4b1] due to [NJ Exec Order 26.4b1]</p> <p>On 07/28/25 at 10:47 AM, the surveyor interviewed the [U.S. FOIA (b)(6)] who confirmed that the resident goes to the [NJ Exec Order 26.4] center three times a week.</p> <p>On 07/29/25 at 11:16 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN#1), who stated that the A/MDS assessment was miscoded by the MDSC/RN #2, who was on vacation at the time. The MDSC/RN #1 added that the [NJ Exec Order 26.4] should be coded at the annual assessment because the resident continues to receive [NJ Exec Order 26.4] treatment.</p> <p>2. The surveyor reviewed Resident # 274's records. The resident was discharged from the facility, and according to the Discharge Return Not Anticipated MDS, an assessment tool used to facilitate the management of care, dated [NJ Exec Order 26.4], the resident was assessed as having an unplanned discharge.</p> <p>A review of Resident # 274's progress notes dated [NJ Exec Order 26.4] revealed the resident was discharged [NJ Ex Order 26.4(b)(1)] [redacted]</p> <p>Review of progress notes upon admission on [NJ Exec Order 26.4] and throughout the resident's stay, there were several notes that indicated that the resident had discharge planning in place.</p> <p>On 07/29/2025 at 11:16 AM, the surveyor interviewed the MDSC/RN#1, who stated that the discharge MDS should have been coded to indicate that the resident had a planned discharge.</p> <p>On 7/30/2025 at 12:07 PM, the survey team met with the [U.S. FOIA, (b) (2)] [redacted] [redacted] [redacted] regarding the above concern, but did not provide further information.</p> |                                                                        |  | F0641                                                                                              | <p>Continued from page 2</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Regional MDS Coordinator and/or designee will conduct audits on discharge assessments of 2 assessments/week x 4 weeks, then 1 assessment x 4 weeks, then 1 assessment/month x 4 months to ensure accuracy coding of planned or unplanned discharge.</p> <p>Results of the audits will be reported to the Quality Assurance Committee.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> |                                                 |                            |

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| F0641<br>SS = D                                                      | Continued from page 3<br>NJAC 8:39-33.2 (d)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | F0641                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                    |  |                                                 |  |
| F0698<br>SS = E                                                      | <p>Dialysis</p> <p>CFR(s): 483.25(l)</p> <p>§483.25(l) Dialysis.</p> <p>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on the interview, medical record review, and review of other pertinent documentation, it was determined that the facility failed to ensure that residents who receive <b>NJ Exec Order 26.4b1</b> receive such services consistent with professional standards of practice for 3 of 3 residents (Resident #2, #11, and #220) reviewed for <b>NJ Exec Order</b> services. The deficient practice was evidenced by the following:</p> <p>1. The surveyor observed Resident #2 seated in a wheelchair in the unit day room on <b>NJ Exec Order 26.4b1</b>. The resident was brought to their room by staff so that the surveyor could interview the resident in a private area. The surveyor interviewed the resident with the aid of an <b>NJ Exec Order 26.4b1</b> since the resident was <b>NJ Exec Order 26.4b1</b>. The resident stated they receive <b>NJ</b> on <b>NJ Exec Order 26.4b1</b> leaving the facility at <b>NJ Exec Order 26.4b1</b> appointment. The resident stated they sometimes get back to the facility as late as 8 pm at which time they eat dinner. The resident stated they are frequently not assessed by the nurse prior to leaving for the <b>NJ Ex</b> clinic at 2 pm.</p> <p>A review of the electronic medical record revealed the following information.</p> <p>The resident was admitted with diagnoses including but not limited to <b>NJ Exec Order 26.4b1</b>.</p> <p>The Order Summary Report included physician's orders for <b>NJ</b> on <b>NJ Exec Order 26.4b1</b> with a pickup time of <b>NJ Exec Order 26.4b1</b>.</p> <p>The <b>NJ Exec Order 26.4b1</b> Report (a 1-page form brought to and back from the <b>NJ</b> clinic) included documentation from the <b>U.S. FOIA (b)(6)</b> and <b>NJ Exec Order 26.4b1</b> information and</p> | F0698                                                                  | <p>Resident #11 and Resident #220</p> <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>The Unit Manager immediately performed the <b>NJ Exec Order 26.4b1</b> assessment.</p> <p>The Regional Clinical Supervisor immediately reviewed the current communication used for <b>NJ Exec Order</b> residents and the <b>NJ Exec Order 26.4b1</b> and revised to include <b>NJ Exec Order 26.4b1</b> assessment to ensure proper monitoring of <b>NJ Exec Order</b> residents.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All dialysis residents have the potential to be affected.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The ADON and/or designee educated all licensed nurses on federal guidelines F698 related to pre-dialysis assessment of the dialysis resident will be documented in the Hemodialysis form.</p> <p>The nurses will be using the Dialysis Communication Form for every resident's appointment.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Director of Nursing and/or Assistant Director of Nursing will conduct audits on pre-dialysis assessments of 3 dialysis residents/week x 4 weeks, then 1 dialysis resident x 4 weeks, then 1x/month x 4 months to ensure that dialysis residents are assessed prior to leaving for Hemodialysis.</p> |                                                                                                    |  | 09/05/2025                                      |  |

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| F0698<br>SS = E                                                      | <p>Continued from page 4</p> <p>assessment written by the facility nurse upon the resident's return to the facility. The form did not have a section for [NJ Ex Order 26.4(b)(1)] information and assessment by the facility nurse.</p> <p>A review of [NJ Ex Order 26.4(b)(1)] electronic progress notes failed to reveal [NJ Ex Order 26.4(b)(1)] nursing assessments.</p> <p>The [NJ Ex Order 26.4(b)(1)] Medication Administration Report included nursing documentation for the following medications which were charted to have been given on [NJ Ex Order 26.4(b)(1)] when the resident was out of the building at [NJ Ex Order 26.4(b)(1)]</p> <p>The surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #2 on 7/28/2025 at 11:18 am. The [U.S. FOIA (b)(6)] stated nursing should check vital signs and the [NJ Ex Order 26.4(b)(1)] prior to the resident leaving the facility and upon return to the facility from the [NJ Ex Order 26.4(b)(1)] clinic. The [U.S. FOIA (b)(6)] was unclear where the [NJ Ex Order 26.4(b)(1)] assessment should be documented.</p> <p>The surveyor interviewed the [U.S. FOIA (b)(6)] on 7/29/2025 at 10:45 am. The [U.S. FOIA (b)(6)] stated she expected nurses to document [NJ Ex Order 26.4(b)(1)] vital signs and [NJ Ex Order 26.4(b)(1)] assessment in the electronic progress notes. The [U.S. FOIA (b)(6)] stated she was aware that [NJ Ex Order 26.4(b)(1)] nursing assessments were inconsistent and stated she is going to formulate a new form with a top section for [NJ Ex Order 26.4(b)(1)] assessment. The [U.S. FOIA (b)(6)] did not discuss medications marked as given when the resident was out of the building.</p> <p>The surveyor discussed concerns with the [U.S. FOIA (b)(6)] on 7/29/2025 at 12:52 pm.</p> <p>2. On 07/29/2025 at 9:32 AM, the surveyor observed Resident #11 sitting on the bed in the room, lying in bed, and able to answer the surveyor's inquiries. The resident stated that they go to [NJ Ex Order 26.4(b)(1)] every [NJ Ex Order 26.4(b)(1)] and leave at around 8:30 AM.</p> <p>On 07/29/2025 10:35 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #11, which revealed the following:</p> <p>A review of the Admission Record (AR, an admission</p> |                                                                        | F0698               | <p>Continued from page 4</p> <p>Results of the audits will be reported to the Quality Assurance Committee.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> |  |                                                 |  |

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                       |  |                                                 |  |
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| F0698<br>SS = E                                                      | <p>Continued from page 5<br/>summary) reflected that Resident #11 was admitted with<br/>diagnoses that included, but were not limited to,<br/><b>NJ Exec Order 26.4b1</b><br/>[REDACTED]</p> <p>A review of the recent quarterly Minimum Data Set<br/>(Q/MDS), (an assessment tool used to facilitate the<br/>management of care), dated <b>NJ Exec Order</b>, indicated that the<br/>facility assessed the residents' <b>NJ Ex Order 26.4(b)(1)</b> using<br/>a Brief Interview for Mental Status (BIMS) score of <b>NJ E</b><br/>[REDACTED], which indicated that the resident had <b>NJ Exec O</b><br/>[REDACTED] Further review of the A/MDS in Section <b>NJ Ex O</b><br/>[REDACTED] stated<br/>that Resident #11 is on <b>NJ Exec Order</b> while a resident.</p> <p>A review of the Order Summary Report (OSR) with a start<br/>date on <b>NJ Exec Order</b> revealed an order of <b>NJ Exec Order</b> days<br/><b>NJ Exec Order 26.4b1</b> at [facility name<br/>redacted] <b>NJ Exec Order 26.4b1</b></p> <p>3. On 07/28/2025 at 10:45 AM, the surveyor observed<br/>Resident #220 in bed, <b>NJ Ex Order 26.4(b)(1)</b>, who stated that<br/>they came back from <b>NJ Exec Order</b> this morning and have been<br/>attending <b>NJ Exec Order 26.4b1</b> for more than [REDACTED] now.</p> <p>On 07/28/2025 10:54 AM, the surveyor reviewed the<br/>hybrid medical record of Resident #220, which revealed<br/>the following:</p> <p>A review of the AR reflected that Resident #220 was<br/>admitted with diagnoses that included, but were not<br/>limited to, <b>NJ Exec Order</b></p> <p>A review of the annual Minimum Data Set (A/MDS), dated<br/><b>NJ Exec Order</b>, indicated that the facility assessed the<br/>residents' <b>NJ Ex Order 26.4</b> status using a BIMS score of <b>NJ E</b><br/>[REDACTED], which indicated that the resident had <b>NJ Exec O</b><br/>[REDACTED]</p> <p>A review of the OSR with a start date on <b>NJ Exec Order 26</b><br/>revealed an order of <b>NJ Exec Order</b> at [facility name<br/>redacted] every <b>NJ Exec Order 26.4b1</b><br/>[REDACTED].</p> <p>A review of the <b>U.S. F</b> form included documentation from the<br/><b>U.S. FOIA (b)(6)</b> and <b>NJ Exec Order 26.4b1</b> information and</p> |                                                                        | F0698               |                                                                                                                          |  |                                                 |  |

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| F0698<br>SS = E                                                      | <p>Continued from page 6<br/>assessment written by the facility nurse upon the resident's return to the facility, but does not contain an assessment section for [NJ Exec Order 26.4b1] assessment by the facility nurse.</p> <p>A review of [NJ Exec Order 26.4b1] electronic Progress Notes (ePN) shows no consistency in [NJ Exec Order 26.4b1] nursing assessments.</p> <p>On 07/28/2025 at 10:47 AM, the [U.S. FOIA (b)(6)] stated that assessing the resident before they go to [NJ Exec Order 26.4b1] is essential. She added that she is aware that some nurses do not evaluate and document the resident before leaving for the [U.S. FOIA (b)(6)] center.</p> <p>On 7/30/2025 at 12:07 PM, the survey team met with the [U.S. FOIA (b)(6)]<br/>[redacted]<br/>[redacted]<br/>[redacted] regarding the above concern, but did not provide further information.</p> <p>A review of the facility policy titled "Dialysis Management (Hemodialysis)" with the last review date on 3/2025 revealed under "Procedure: If dialysis is provided at off-site Dialysis Center: 1. Assure physician order includes: Medication administration times adjusted on dialysis treatment days." The facility policy does not include a pre-dialysis assessment procedure.</p> <p>NJAC 8:39-11.2(b), 27.1(a)</p> |                                                                        | F0698               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                 |  |
| F0755<br>SS = E                                                      | <p>Pharmacy Srvcs/Procedures/Pharmacist/Records</p> <p>CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        | F0755               | <p>[NJ Ex Order 26.4(b)(1)] Monitor Control Testing</p> <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>The Unit Manager immediately checked all the [NJ Exec O]<br/>[redacted] using the control solution and all found to be within [NJ Ex Order 26.4(b)(1)]</p> <p>The Regional Clinical Supervisor immediately reviewed and updated the [NJ Exec Order 26.4b1] control log form to accommodate the [NJ Exec Order 26.4b1]</p> |  | 09/05/2025                                      |  |

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| F0755<br>SS = E                                                      | <p>Continued from page 7<br/>assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§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</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a.) quality control testing (calibration) was conducted for the <b>NJ Ex Order 26.4(b)(1)</b> monitors, simultaneously used for residents, observed on two (2) of four (4) medication carts inspected, and identified for 7 of 7 medication carts; b.) timely receipt of medication <b>NJ Exec Order 26.4b1</b> ) for administration, and prevent borrowing from another resident's supply for one (1) of 8 residents observed during the medication administration.</p> <p>The evidence was as follows:</p> <p>1. On 7/30/25 at 9:17 AM, in the presence of the Licensed Practical Nurse (LPN #1) the surveyor began the inspection of medication cart #1 on the <b>NJ Exec Order 26.4b1</b> floor and observed <b>NJ Exec Order 26.4b1</b> LPN #1 stated she disinfected the <b>NJ Exec Order 26.4b1</b> after she measured the amount of <b>NJ Exec Order 26.4b1</b> in a <b>NJ Exec Order 26.4b1</b> sample of a resident. The <b>NJ Exec Order 26.4b1</b> required drying time after disinfection, and while <b>NJ Exec Order 26.4b1</b> was drying, she used the <b>NJ Exec Order 26.4b1</b> the next resident's <b>NJ Exec Order 26.4b1</b>.</p> |                                                                        | F0755               | <p>Continued from page 7<br/>calibration per cart.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents on blood glucose monitoring have the potential to be affected.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The ADON and/or designee educated all licensed nurses on federal regulations F755 related to the quality control solution testing (calibration) of all the <b>NJ Exec Order 26.4b1</b> monitors must be performed in accordance with manufacturer's instructions and quality assurance protocols to ensure accuracy and reliability of <b>NJ Exec Order 26.4b1</b> results obtained. The results of the <b>NJ Exec Order 26.4b1</b> will be logged in the <b>NJ Exec Order 26.4b1</b> control log form.</p> <p>All nurses will be using the updated <b>NJ Exec Order 26.4b1</b> control log form on each medication carts to monitor all the <b>NJ Exec Order 26.4b1</b> monitor.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The DON/ADON will conduct audits on glucometer records 3x/week x 4 weeks, then 1x/4 weeks, then 1x/month x 4 months to ensure accuracy and reliability of blood glucose results.</p> <p>Results of the audits will be reported to the Quality Assurance Committee.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> <p>Resident #131</p> |  |                                                 |  |

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                 |
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| F0755<br>SS = E                                                      | <p>Continued from page 8</p> <p>A review of the [REDACTED] floor [REDACTED] [REDACTED] control record reflected only one(1) [REDACTED] was [REDACTED] daily from [REDACTED].</p> <p>At that time, LPN #1 stated that the 11:00 AM – 7:00 PM shift nurse checked and [REDACTED] the [REDACTED] and was also unable to identify which [REDACTED] was [REDACTED] for accuracy. LPN #1 stated she was not responsible and did not [REDACTED] the U.S. FOIA (b)(6) on her shift.</p> <p>At that time, the surveyor, and the [REDACTED] reviewed the [REDACTED] control record together. The RN/UM #1 confirmed and acknowledged the record reflected only 1 [REDACTED] was calibrated, checked for functionality and accuracy.</p> <p>A review of the [REDACTED] floor's [REDACTED] control record from [REDACTED] on the [REDACTED] floor reflected only one [REDACTED] was [REDACTED] checked for functionality and accuracy.</p> <p>2.) On 7/30/25 at 9:43 AM, in the presence of the Licensed Practical Nurse (LPN #2) the surveyor began the inspection of medication cart #1 on the [REDACTED] floor and observed [REDACTED].</p> <p>A review of the [REDACTED] floor [REDACTED] control record reflected only [REDACTED] daily from [REDACTED].</p> <p>At that time, LPN #1 stated that the 11:00 AM – 7:00 PM shift nurse checked and [REDACTED] the [REDACTED] and was also unable to identify which [REDACTED] was [REDACTED] for accuracy. LPN #1 stated she was not responsible and did not [REDACTED] the [REDACTED] on her shift.</p> <p>At that time, LPN #2 stated she used both [REDACTED], [REDACTED] after each use, let the [REDACTED] dry after [REDACTED] and switched to the other [REDACTED], in-between residents.</p> <p>At that time, LPN #2 stated that the 11:00 AM – 7:00 PM shift nurse checked and calibrated the [REDACTED] and was also unable to identify which [REDACTED] was [REDACTED] for accuracy. LPN #1 stated she was not responsible and did not [REDACTED] the [REDACTED] on her shift.</p> <p>On 7/30/25 at 9:43 AM, the surveyor and the RN/UM #2 reviewed the [REDACTED] control record together. The RN/UM #1 confirmed and acknowledged the record reflected only 1 [REDACTED] was [REDACTED], checked for</p> | F0755                                                                  | <p>Continued from page 8</p> <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>The Regional Clinical Supervisor and the Unit Manager immediately educated the [REDACTED] on unavailable and/or missing medications and borrowing medication from another resident's supply is not an acceptable practice.</p> <p>The Unit Manager immediately notified the physician and the resident's family of the medication that was borrowed.</p> <p>The Unit Manager immediately ordered the medication at the facility's expense to replace the borrowed medication from another resident's supply.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The ADON and/or designee educated all licensed nurses on federal guidelines F755 related to missing medications and prevention of borrowing medication from another resident's supply.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The DON and/or ADON will conduct audits on medications of 3 residents/week x 4 weeks, then 1x/4 weeks, then 1x/month x 4 months to ensure that nurses are not borrowing medications from another resident's supply.</p> <p>Results of the audits will be reported to the Quality Assurance Committee.</p> |                                                 |

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                               |                                                                                                                                                                                                                                                  | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |                                                                                                                                                                                                                                                  |                                                 |                            |
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| F0755<br>SS = E                                                      | <p>Continued from page 9<br/>functionality and accuracy.</p> <p>A review of the [REDACTED] floor's [REDACTED] control record from [REDACTED] on the [REDACTED] floor reflected only [REDACTED], checked for functionality and accuracy.</p> <p>Further review of the [REDACTED] control record for the [REDACTED] floor reflected only [REDACTED], checked for functionality and accuracy.</p> <p>On 7/30/25 at 12:19 PM, in the presence of the survey team, the [REDACTED] the [REDACTED] the surveyor discussed the concerned that only [REDACTED] were [REDACTED] checked for functionality and accuracy. The [REDACTED] stated she would conduct an investigation.</p> <p>On 7/31/25 at 10:11 AM, during a meeting with the survey team, the [REDACTED], and the [REDACTED] confirmed there were [REDACTED] in the cart and the 11:00 PM to 7:00 PM nurse checked only the [REDACTED] and not the [REDACTED]. The [REDACTED] stated that the policy was revised to ensure both [REDACTED] and checked for functionality.</p> <p>A review of the provided facility policy Control Solution Testing for Blood Glucose Monitor dated/reviewed on 7/29/25, included that to ensure accuracy and reliability of the blood glucose results obtained from the (brand redacted) bg monitoring system, control solution testing would be performed in accordance with manufacturer's instructions and quality assurance protocols.</p> <p>3. On 7/29/25 at 8:47 AM, the surveyor, while observing the medication pass (med-pass), observed the [REDACTED] assigned to the [REDACTED] floor medication cart prepare and administer medications for Resident #131. The surveyor observed that the [REDACTED] could not locate the medication [REDACTED], a medication used help [REDACTED] in [REDACTED]. The surveyor observed the [REDACTED] locate the same medication that was dispensed and labeled for another resident. The surveyor asked the [REDACTED] what the usual procedure and policy for missing medications was. The [REDACTED] stated that they would search for the medication to see if another resident was taking the same thing and borrow theirs. The surveyor observed the [REDACTED] administer</p> |                                                                        |  | F0755                                                                                              | <p>Continued from page 9</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> |                                                 |                            |

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                       |  |                                                 |  |
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| F0755<br>SS = E                                                      | <p>Continued from page 10<br/>all due medications as well as the [REDACTED] that was<br/>from another resident's stock.</p> <p>The surveyor concluded the med-pass observation</p> <p>.</p> <p>The surveyor reviewed the electronic medical record<br/>(EMR) for Resident #131 which revealed the following:</p> <p>An admission record (AR), a document that includes<br/>pertinent resident information such as admission dates<br/>and diagnoses, which reflected that the resident had<br/>diagnoses that included but were not limited to<br/>[REDACTED]<br/>[REDACTED]<br/>[REDACTED]</p> <p>A review of the resident's Comprehensive Minimum Data<br/>Set (MDS), an assessment tool used to facilitate the<br/>management of care, with an assessment reference date<br/>of [REDACTED], indicated the facility assessed the<br/>resident's cognition using a Brief Interview Mental<br/>Status (BIMS) test. Resident #131 scored a [REDACTED]<br/>which indicated the resident had [REDACTED]<br/>[REDACTED] Part [REDACTED] of the MDS reflected that the<br/>resident was receiving a medication classified as a<br/>[REDACTED]<br/>[REDACTED]</p> <p>The surveyor reviewed Resident #131's electronic<br/>medication administration record (eMAR), a document<br/>that shows the resident medication orders, when they<br/>are schedules and who administered. The eMAR reflected<br/>that the resident had an order for [REDACTED],<br/>scheduled at 9:00 AM and was administered the<br/>medication on [REDACTED]</p> <p>The surveyor reviewed an Order Audit Report (OAR) and<br/>an Order Summary Report (OSR), each of which reflected<br/>that the resident had a current active physician's<br/>order for [REDACTED]</p> <p>On 7/29/25 at 9:15 AM, the [REDACTED] U.S. FOIA (b)(6)<br/>[REDACTED] informed the surveyor that the [REDACTED] U.S. FOIA on the [REDACTED] NJ Ex<br/>floor wished to speak with him. At 9:41AM on the same<br/>day, the surveyor interviewed the [REDACTED] U.S. FOIA previously<br/>observed during the med-pass. The [REDACTED] U.S. FOIA stated that they</p> |                                                                        | F0755               |                                                                                                                          |  |                                                 |  |

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| F0755<br>SS = E                                                      | <p>Continued from page 11<br/>found the medication, [REDACTED] for Resident #131<br/>and showed the medication to the surveyor. The [REDACTED] also<br/>stated that the facility policy is not to borrow<br/>medications if they can't be found and to get them from<br/>the facility backup supply.</p> <p>On 7/29/2025 at 12:49 PM, the survey team met with the<br/>[REDACTED] U.S. FOIA (b)(6) and the [REDACTED] [REDACTED]<br/>to discuss concerns. The<br/>surveyor informed the facility of the concern with<br/>borrowing medications from other residents. The [REDACTED] [REDACTED]<br/>responded that the policy is never to borrow and to<br/>check the facility back up supply and the [REDACTED] [REDACTED] who did<br/>the borrowing was re-educated.</p> <p>On 7/29/25 at 1:05 PM, the surveyor interviewed the<br/>facility [REDACTED] U.S. FOIA (b)(6) by phone. The<br/>surveyor asked the [REDACTED] [REDACTED] what the nurses should do if a<br/>medication is not available. The [REDACTED] [REDACTED] stated that [REDACTED] [REDACTED]<br/>should check if the medications is available in the<br/>facility backup. If it is not there, then the<br/>resident's physician should be called for instructions.<br/>The surveyor asked if the staff should borrow meds from<br/>other residents. The [REDACTED] [REDACTED] stated no, medications should<br/>never be borrowed from any other resident.</p> <p>On 7/30/2025 at 12:09 PM the survey team met with the<br/>[REDACTED] U.S. FOIA (b)(6) to discuss concerns and get<br/>responses. The [REDACTED] [REDACTED] provided copies of attendance for<br/>education given to nurses regarding missing medications<br/>and an individual investigation for the nurse that was<br/>witnessed borrowing medications.</p> <p>The facility did not provide any further pertinent<br/>information.</p> <p>The surveyor reviewed the facility provided policy<br/>titled Medication Administration dated revised 9/2024.<br/>The policy reflected, under Purpose: Right<br/>resident/patient. The policy did not reflect any other<br/>information related to missing medications.</p> <p>NJAC 8:39-29.2(d)</p> | F0755                                                                  |                                                                                                                                      |                                                                                                    |  |                                                 |  |
| F0760<br>SS = D                                                      | <p>Residents are Free of Significant Med Errors</p> <p>CFR(s): 483.45(f)(2)</p> <p>The facility must ensure that its-</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | F0760                                                                  | <p>Resident #71</p> <p>What corrective action was accomplished for the<br/>resident found to have been affected by the deficient</p> |                                                                                                    |  | 09/05/2025                                      |  |

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| F0760<br>SS = D                                                      | <p>Continued from page 12</p> <p>\$483.45(f)(2) Residents are free of any significant medication errors.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, interview, and record review it was determined the facility failed to follow a physician's order for an <b>NJ Exec Order 26.4b1</b> medication and acceptable professional standards of practice for 1 of 35 residents reviewed.</p> <p>This deficient practice is evidenced by the following:</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist."</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>On 7/29/2025 at 11:28 AM, the surveyor reviewed the electronic medical records (EMR) of Resident #71.</p> <p>The Admission Record (a summary of important information about the resident) revealed that Resident #71 had diagnoses that included but were not limited to, <b>NJ Exec Order 26.4b1</b>.</p> <p>A comprehensive Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated <b>NJ Exec Order 26.4b1</b>, indicated the facility assessed the resident's cognition using a Brief Interview Mental</p> |                                                                        | F0760               | <p>Continued from page 12 practice?</p> <p>The Unit Manager immediately notified the physician and clarified the <b>NJ Exec Order 26.4b1</b>.</p> <p>The Regional Clinical Supervisor immediately re-in-service the nurses who did not follow the physician's order when administering the <b>NJ Exec Order 26.4b1</b> to Resident #71.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The ADON and/or designee educated all licensed nurses on federal guidelines F760 related to following the physician's order when administering medications.</p> <p>The DON and DON educated the Nurse Practitioners and Physicians on how to write a specific order according to the medical standard of practice.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The DON/ADON will conduct medication passes on licensed nurses 3x/week x 4 weeks, then 1x/4 weeks, then 1x/month x 4 months to ensure that nurses are following physician's orders when administering medications.</p> <p>Results of the audits will be reported to the Quality Assurance Committee.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> |  |                                                 |  |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                       |                                                 |
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| F0760<br>SS = D                                                      | <p>Continued from page 13</p> <p>Status (BIMS) test. Resident #71 scored a [REDACTED] which indicated the resident had [REDACTED] Section [REDACTED] (for [REDACTED]) indicated the resident received [REDACTED].</p> <p>A physician's order dated [REDACTED] revealed for [REDACTED].</p> <p>The order was scheduled to be administered at [REDACTED].</p> <p>A review of the [REDACTED] Medication Administration Record (MAR) revealed the following for the [REDACTED].</p> <p>-The order entry specified, [REDACTED].</p> <p>- On [REDACTED], it was documented the resident's [REDACTED] results was [REDACTED] units were administered to the resident.</p> <p>-On [REDACTED], it was documented the resident's [REDACTED] results was [REDACTED] units were administered to the resident.</p> <p>- On [REDACTED], it was documented the resident's [REDACTED] results was [REDACTED] units were administered to the resident.</p> <p>On 7/30/2025 at 10:11 AM, the surveyor interviewed a [REDACTED] U.S. FOIA (b)(6) ) about Resident #71's [REDACTED] order indicating [REDACTED]. The [REDACTED] stated that it meant for the [REDACTED] be given to resident should be [REDACTED] indicated by the [REDACTED].</p> <p>The surveyor reviewed the physician's order and the MAR with the [REDACTED]. The [REDACTED] stated that there should have been a separate order entered for the [REDACTED] administration to specify the [REDACTED] sliding scale to be followed. The [REDACTED] acknowledged the order should have been clarified by the nurses and that she would clarify the order.</p> | F0760                                                                  |                                                                                                                          |                                                 |

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |  |
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| F0760<br>SS = D                                                      | <p>Continued from page 14</p> <p>On 7/30/2025 at 11:17 AM, the surveyor informed the U.S. FOIA (b)(6) of the concern regarding the NJ Exec Order order for Resident #71. The U.S. FOIA (b) and the U.S. FOIA (b) stated they would review and follow up with the U.S. FOIA (b).</p> <p>On 7/30/2025 at 12:09 PM, the surveyor informed the U.S. FOIA (b)(6) of the concern for Resident #71's NJ Exec Order order. The U.S. FOIA (b)(6) stated that the order was clarified by the U.S. FOIA (b) and provided the surveyor a copy of the new order entry. The surveyor requested the facility's medication administration policy, and any other policy related to NJ Exec Order administration.</p> <p>On 7/30/2025 at 12:31 PM, the surveyor interviewed the U.S. FOIA (b)(6) over the phone about the concern regarding Resident's #71 NJ Exec Order order and no recommendations were noted for the resident's medication regimen review (MRR) dated NJ Exec Order.</p> <p>On 7/31/2025 at 8:59 AM, the U.S. FOIA (b) called back and informed the surveyor that the U.S. FOIA (b) had missed the U.S. FOIA (b) comment on the order during the MRR. The U.S. FOIA (b) further explained that it was not a typical NJ Exec Order order.</p> <p>On 7/31/2025 at 10:11 AM, the U.S. FOIA (b)(6) met with the survey team. The U.S. FOIA (b) stated the NJ Exec Order order had been clarified for Resident #71, the facility audited NJ Exec Order orders for other residents, provided education to nursing staff, and one on one in-service education was provided to the nurses who did not follow the physician's order when administering the NJ Exec Order 26.4b1 to Resident #71. There was no additional response provided by the facility's management.</p> <p>The surveyor reviewed the facility provided policy titled, "Medication Administration", with a last revised date of September 2024. Under Purpose revealed: "To administer the following...Right medication...Right dose... Right documentation...Right time"</p> <p>Under Procedure of the policy revealed: "...9. Read the</p> |                                                                        | F0760               |                                                                                                                          |  |                                                 |  |

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                               |  | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |  |
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| F0760<br>SS = D                                                      | Continued from page 15<br>Medication Administration Record (MAR) for the ordered<br>medication, dose, dosage form, route, and time..."                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | F0760                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                    |  |                                                 |  |
| F0761<br>SS = D                                                      | NJAC 8:39-11.2 (b); 29.2(d)<br><br>Label/Store Drugs and Biologicals<br><br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br><br>Drugs and biologicals used in the facility must be<br>labeled in accordance with currently accepted<br>professional principles, and include the appropriate<br>accessory and cautionary instructions, and the<br>expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal<br>laws, the facility must store all drugs and biologicals<br>in locked compartments under proper temperature<br>controls, and permit only authorized personnel to have<br>access to the keys.<br><br>§483.45(h)(2) The facility must provide separately<br>locked, permanently affixed compartments for storage of<br>controlled drugs listed in Schedule II of the<br>Comprehensive Drug Abuse Prevention and Control Act of<br>1976 and other drugs subject to abuse, except when the<br>facility uses single unit package drug distribution<br>systems in which the quantity stored is minimal and a<br>missing dose can be readily detected.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and review of<br>pertinent facility documents, it was determined that<br>the facility failed to properly store Controlled<br>Substance medications (CDS) securely per regulations<br>and standards of practice. This deficient practice was<br>identified in one (1) of four (4) medication carts (med<br>carts) observed in the facility.<br><br>This deficient practice was evidenced by the following:<br><br>Reference: New Jersey Statutes Annotated, Title 45,<br>Chapter 11. Nursing Board. The Nurse Practice Act for<br>the State of New Jersey states: "The practice of<br>nursing as a licensed practical nurse is defined as | F0761                                                                  | <p>What corrective action was accomplished for the<br/>resident found to have been affected by the deficient<br/>practice?</p> <p>The Regional Clinical Supervisor immediately checked<br/>the floor CDS lock box and re-organized so that the<br/>top closes easily.</p> <p>The Unit Manager immediately educated the medication<br/>nurse on how to care and lock the CDS box.</p> <p>How will other residents who may have the potential to<br/>be affected be identified?</p> <p>Residents on Controlled Dangerous Substance (CDS) have<br/>the potential to be affected.</p> <p>What measures will be put into place or what systematic<br/>changes will be made to ensure that the deficient<br/>practice does not reoccur?</p> <p>The ADON and/or designee educated all licensed nurses<br/>on the proper storage of CDS box on the med carts.</p> <p>How will the corrective action(s) be monitored to<br/>ensure the deficient practice will not reoccur and what<br/>QA program will be put into place?</p> <p>The DON/ADON will conduct audits on CDS lock boxes<br/>3x/week x 4 weeks, then 1x/4 weeks, then 1x/month x 4<br/>months to ensure that proper storage of CDS lock boxes.</p> <p>Results of the audits will be reported to the Quality<br/>Assurance Committee.</p> <p>The QAPI Committee will make recommendations based upon<br/>the results of the audits.</p> <p>The QAPI Committee will recommend tapering and<br/>dissolution of audits once consistent compliance has<br/>been achieved.</p> |                                                                                                    |  | 09/05/2025                                      |  |

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| F0761<br>SS = D                                                      | <p>Continued from page 16<br/>performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist."</p> <p>On 7/30/2025 at 10:08 AM the surveyor began to inspect selected medication (med) storage areas in the facility. The surveyor observed the following:</p> <p>On the facility <b>NJ 609</b> floor, the surveyor, in the presence of the <b>U.S. FOIA (b)(6)</b> assigned to the med cart, accessed the med cart. The surveyor opened the drawer where the CDS are stored. The surveyor observed that the lock box containing the CDS was not closed or locked and was readily opened by the surveyor without a key. The surveyor asked the <b>U.S. FOIA (b)(6)</b> if the CDS box should be locked. The <b>U.S. FOIA (b)(6)</b> stated, yes it should be locked, but the medications inside keep it from closing easily and sometimes you must shut it very hard.</p> <p>The surveyor concluded the inspection of the med cart.</p> <p>On 7/30/2025 at 12:09 PM, the survey team met with the <b>U.S. FOIA (b)(6)</b> to discuss concerns. The surveyor discussed the concern with the CDS storage box not being locked.</p> <p>On 7/30/25 at 2:00 PM, the surveyor interviewed the facility <b>U.S. FOIA (b)(6)</b> by phone. The surveyor asked the <b>U.S. FOIA (b)(6)</b> what the correct way was to store CDS in the med cart. The <b>U.S. FOIA (b)(6)</b> stated that CDS should be stored behind two (2) separate locks, in its own compartment. The med cart should be locked and the CDS box should be locked. The surveyor informed the <b>U.S. FOIA (b)(6)</b> about the concern with the <b>NJ 609</b> floor med cart lock box that was accessible to the surveyor without a key and was not closing properly.</p> <p>On 7/31/2025 at 10:11 AM, the survey team met with the <b>U.S. FOIA, (b) (2)</b> for responses to concerns. The <b>U.S. FOIA (b)(6)</b> stated that the CDS lock box was fixed by re-organizing the way the medications fit inside so the</p> |                                                                        | F0761               |                                                                                                                          |  |                                                 |  |

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| F0761<br>SS = D                                                      | <p>Continued from page 17<br/>top closes easily. The [REDACTED] stated that staff education<br/>on storage of CDS was also performed.</p> <p>The facility did not provide any further pertinent<br/>information.</p> <p>The surveyor reviewed the facility policy titled<br/>Medication Storage with a last reviewed date of 9/2024.<br/>The policy reflected, under line 1 Narcotics and<br/>Controlled Substances: Schedule II drugs... are stored<br/>under double-lock and key.</p> <p>The surveyor reviewed the facility policy titled<br/>Medication Administration with a revision date of<br/>9/2024. The policy reflected, under Procedure, line 27<br/>Assure controlled substances are double locked.</p> <p>NJAC 8:39-29.7 (c)</p> |                                                                        | F0761               |                                                                                                                          |  |                                                 |  |

New Jersey State Department of Health

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| S0000                                                                | Initial Comments<br><br>The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                        | S0000               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | 09/05/2025                                      |  |
| S0560                                                                | Mandatory Access to Care<br><br>CFR(s): 8:39-5.1(a)<br><br>The facility shall comply with applicable Federal, State, and local laws, rules, and regulations.<br><br>This LICENSURE REQUIREMENT is NOT MET as evidenced by:<br><br>REPEAT DEFICIENCY<br><br>Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios for 14 of 14 day shifts as mandated by the state of New Jersey.<br><br>This deficient practice was evidenced by the following:<br><br>Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.<br><br>Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21.<br><br>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care |                                                                        | S0560               | S560 – Mandatory Access to Care<br><br>There was no negative outcome to residents on the shifts identified as not meeting the NJ staffing requirements during the 7 a.m. to 3 p.m. (day shift) from 7/6/25 to 7/19/25.<br><br>All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement ratios.<br><br>The following measures have been put into place to prevent the deficient practice from recurring:<br><br>Advertisement / Job postings for CNAs have been posted on social media websites as well as flyers posted in local supermarkets and stores that we are hiring.<br><br>Facility updated and increased sponsorships of advertisements on job search platforms.<br><br>Incentives are offered to CNAs to work extra shifts such as bonuses and raffles.<br><br>Human Resources has reached out to CNA schools to advise we are hiring and willing to train new graduates. |  | 10/05/2025                                      |  |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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New Jersey State Department of Health

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>060902</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                 |  |
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| S0560                                                                | <p>Continued from page 1<br/>staff -to-resident ratios:</p> <p>(1) one certified nurse aide to every eight residents for the day shift;</p> <p>(2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and</p> <p>(3) 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 certified nurse aide and perform certified nurse aide duties</p> <p>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.</p> <p>(2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...</p> <p>A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period beginning 7/6/2025 and ending 7/19/2025 revealed the facility was not in compliance with the State of New Jersey minimum</p> |                                                                        |  | S0560                                                                                              | <p>Continued from page 1</p> <p>Facility increased starting rates for CNA and LPN to help with recruiting new employees.</p> <p>The Administrator/Designee will review the staffing schedule weekly to monitor the staffing ratio on the day shift for 3 months.</p> <p>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.</p> <p>The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p> <p>The Date of Completion is October 5, 2025.</p> <p>The administrator is responsible for the implementation of the Plan of Correction.</p> |                                                 |  |

New Jersey State Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |                                                                                                                          |                                                 |                            |
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| S0560                                                                | <p>Continued from page 2<br/>staffing requirements.</p> <p>The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:</p> <p>-07/06/25 had 26 CNAs for 264 residents on the day shift, required at least 33 CNAs.</p> <p>-07/07/25 had 29 CNAs for 264 residents on the day shift, required at least 33 CNAs.</p> <p>-07/08/25 had 28 CNAs for 264 residents on the day shift, required at least 33 CNAs.</p> <p>-07/09/25 had 28 CNAs for 264 residents on the day shift, required at least 33 CNAs.</p> <p>-07/10/25 had 27 CNAs for 266 residents on the day shift, required at least 33 CNAs.</p> <p>-07/11/25 had 27 CNAs for 266 residents on the day shift, required at least 33 CNAs.</p> <p>-07/12/25 had 26 CNAs for 265 residents on the day shift, required at least 33 CNAs.</p> <p>-07/13/25 had 26 CNAs for 264 residents on the day shift, required at least 33 CNAs.</p> <p>-07/14/25 had 28 CNAs for 262 residents on the day shift, required at least 33 CNAs.</p> <p>-07/15/25 had 28 CNAs for 259 residents on the day shift, required at least 32 CNAs.</p> <p>-07/16/25 had 27 CNAs for 259 residents on the day shift, required at least 32 CNAs.</p> <p>-07/17/25 had 27 CNAs for 259 residents on the day shift, required at least 32 CNAs.</p> <p>-07/18/25 had 27 CNAs for 259 residents on the day shift, required at least 32 CNAs.</p> <p>-07/19/25 had 27 CNAs for 261 residents on the day shift, required at least 33 CNAs.</p> <p>On 7/30/2025 at 10:44 AM, the surveyor interviewed the Staffing Coordinator (SC) who stated staffing had been good and believed the facility was meeting state minimum staffing requirements. The SC stated that sometimes there were staff callouts, and she would call to find other staff members to cover for the shift. The SC further explained the facility had a staffing grid</p> |                                                                        |  | S0560                                                                                              |                                                                                                                          |                                                 |                            |

New Jersey State Department of Health

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| S0560                                                                | Continued from page 3<br>to ensure there was adequate staffing in the facility.<br><br>On 7/30/2025 at 12:09 PM, the surveyor informed the<br>Licensed Nursing Home Administrator (LNHA), the Vice<br>President of Operations (VPO), the Regional Director of<br>Nursing (RDON), and the Vice President of Clinical<br>Services about the above concerns for minimum staffing<br>ratios not being met.<br><br>On 7/31/2025 at 10:11 AM, the LNHA, the VPO, the RDON,<br>and the VPCS met with the survey team. There was no<br>additional information provided by the facility.                                                                                                                                                                                                                                                                                                                                                                                                   | S0560                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    |  |                                                 |  |
| S1680                                                                | Mandatory Nurse Staffing<br><br>CFR(s): 8:39-25.2(b)(1)&(2)<br><br>(b) The facility shall provide nursing services by<br>registered professional nurses, licensed practical<br>nurses, and nurse aides (the hours of the director of<br>nursing are not included in this computation, except<br>for the direct care hours of the director of nursing in<br>facilities where the director of nursing provides more<br>than the minimum hours required at N.J.A.C.<br>8:39-25.1(a)) on the basis of:<br><br>1. Total number of residents multiplied by 2.5<br>hours/day; plus<br><br>2. Total number of residents receiving each service<br>listed below, multiplied by the corresponding number of<br>hours per day:<br><br>Wound care 0.75 hour/day<br><br>Nasogastric tube feedings and/or gastrostomy 1.00<br>hour/day<br><br>Oxygen therapy 0.75 hour/day<br><br>Tracheostomy 1.25 hours/day<br><br>Intravenous therapy 1.50 hours/day<br><br>Use of respirator 1.25 hours/day | S1680                                                                  | S1680 – Mandatory Nurse Staffing<br><br>There was no negative outcome to residents on the<br>shifts identified as not meeting the minimum staffing<br>levels for 7/6/25, 7/12/25 and 7/13/25.<br><br>All residents have the potential to be affected by the<br>deficient practice of not meeting the minimum staffing<br>level.<br><br>The following measures have been put into place to<br>prevent the deficient practice from recurring:<br><br>Advertisement / Job postings for RN's, LPN's and CNA's<br>have been posted on social media websites as well as<br>flyers posted in local supermarkets and stores that we<br>are hiring.<br><br>Incentives are offered to RN's, LPN's and CNA's to work<br>extra shifts such as gift cards and raffles.<br><br>Administrator has reached out to RN's, LPN's and CNA's<br>schools to advise we are hiring and willing to train<br>new graduates.<br><br>Facility updated and increased sponsorships of<br>advertisements on job search platforms.<br><br>Facility increased starting rates for CNA and LPN to<br>help with recruiting new employees.<br><br>The Administrator/Designee will review the staffing<br>schedule weekly to monitor the staffing levels for 3<br>months.<br><br>All results of the monitoring will be presented to the |                                                                                                    |  | 10/05/2025                                      |  |

New Jersey State Department of Health

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| S1680                                                                | <p>Continued from page 4</p> <p>Head trauma stimulation/advanced neuromuscular/orthopedic care 1.50 hours/day</p> <p>This LICENSURE REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on review of the Nurse Staffing Reports for the weeks of 7/6/2025 and 7/13/2025, it was determined that the facility failed to provide at least the minimum staffing levels for 3 of 14 days. The required staffing hours and actual staffing hours were as follows:</p> <p>1. For the week of 7/6/2025</p> <p>Required Staffing Hours: 748.75</p> <p>-07/06/25 had 720 actual staffing hours, for a difference of -28.75 hours.</p> <p>-07/12/25 had 744 actual staffing hours, for a difference of -4.75 hours.</p> <p>2. For the week of 7/13/2025</p> <p>Required Staffing Hours: 735</p> <p>-07/13/25 had 704 actual staffing hours, for a difference of -31 hours.</p> <p>On 7/30/2025 at 12:09 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the Vice President of Operations (VPO), the Regional Director of Nursing (RDON), and the Vice President of Clinical Services about the above concerns for staffing.</p> <p>On 7/31/2025 at 10:11 AM, the LNHA, the VPO, the RDON, and the VPCS met with the survey team. There was no additional information provided by the facility.</p> |                                                                        | S1680               | <p>Continued from page 4</p> <p>QA committee for review and any additional monitoring or modification of this plan monthly for 3 months.</p> <p>The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance.</p> <p>The Date of Completion is October 5, 2025.</p> <p>The administrator is responsible for the implementation of the Plan of Correction.</p> |  |                                                 |  |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS                 |                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING                                                                     |  | (X3) DATE SURVEY COMPLETED<br><b>09/14/2025</b> |  |
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| F0000                                                                | INITIAL COMMENTS<br><br>An offsite/desk review of the facility's Plan of Correction was conducted on 9/14/2025 in relation to the 7/31/2025 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. |                                                                        | F0000               |                                                                                                                          |  |                                                 |  |

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

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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New Jersey State Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |                                                                                                                          |                                                 |                            |
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| S0000                                                                | Initial Comments<br><br>An offsite/desk review of the facility's Plan of<br>Correction was conducted on 9/14/2025 in relation to<br>the 7/31/2025 State of New Jersey Re-Licensure survey.<br>The facility was found to be in compliance with the<br>Standards in the New Jersey Administrative Code,<br>Chapter 8:39, Standards for Licensure of Long Term Care<br>Facilities |                                                                        |  | S0000                                                                                              |                                                                                                                          |                                                 |                            |

Office of Primary Care and Health Systems Management

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 0...</b><br>B. WING                                                                                                                                                          |  | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                        |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                                                                                                                                           |  |                                                 |  |
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| K0000                                                                | <p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations from 07/28/2025 to 07/30/2025. Hudson View Health Care Center was found to be in NON-COMPLIANCE with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>Hudson View contains a total of 11 floors.</p> <p>Floor 10 is for physical therapy....Currently being renovated.</p> <p>Floors 9 thru 3 are resident room floors. Each floor contains 2 smoke compartments and 39 resident rooms.</p> <p>Floor 2 contains the Kitchen, Staff lounge and Nursing/Business offices.</p> <p>Floor 1 contains the Lobby/ parking garage and Administrative offices.</p> <p>Ground floor contains the boiler room/laundry room/storage rooms and the emergency generator.</p> <p>Hudson View Health Care Center is a 10-story building with a basement that was built in the 1960's. It is composed of Type I protected construction. The facility is divided into 14 - smoke zones. The percentage of the building served by the emergency generator is not known per the U.S. FOIA (b)(6) (REDACTED). Documentation provided by the U.S. FOIA (b)(6) (REDACTED) indicated that the HVAC system, walk in fridges and freezers, fire pumps and the PTAC units in residents' rooms are not hooked up to the emergency generator. The current occupied beds are 263 of 273.</p> |                                                                        | K0000               |                                                                                                                                                                                                                                              |  | 09/05/2025                                      |  |
| K0211<br>SS = F                                                      | <p>Means of Egress - General</p> <p>CFR(s): NFPA 101</p> <p>Means of Egress - General</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | K0211               | <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>The facility immediately contacted their vendor come in to give a quote to relocate the ductwork in the center</p> |  | 09/25/2025                                      |  |

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

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| K0211<br>SS = F                                                      | <p>Continued from page 1</p> <p>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.</p> <p>18.2.1, 19.2.1, 7.1.10.1</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation on 07/30/2025 at 9:31 AM, it was determined that they facility failed to ensure that the exit discharges, exit locations and accesses were in accordance with NFPA 101:2012 Edition, Sections 19.2.1 and 7.7.1.1. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation on 07/30/2025 at 9:31 AM revealed that exit access to a public way was reduced to approximately 24 inches when exiting the South Side exit stairway enclosure on floor 1. Metal exhaust ductwork was extending through metal floor grates directly in the center of the exit access pathway.</p> <p>N.J.A.C 8:39 - 31.2 (e)</p> | K0211                                                                  | <p>Continued from page 1</p> <p>of the walkway to ensure proper means of egress.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The Administrator educated the <b>U.S. FOIA (b)(6)</b> that exit discharges, exit locations and accesses need to be in accordance with NFPA 101:2012 Edition, Sections 19.2.1 and 7.7.1.1.</p> <p>Maintenance Director/Designee will ensure means of egress are continuously maintained and free of obstructions as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately.</p> <p>The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Maintenance Director/Designee will present the inspection results to the Quality Assurance Performance Improvement (QAPI) committee monthly x 6 months.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> <p>The Date of Completion is September 25th, 2025</p> |                                                                                                    |  |                                                 |  |
| K0222<br>SS = F                                                      | <p>Egress Doors</p> <p>CFR(s): NFPA 101</p> <p>Egress Doors</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | K0222                                                                  | <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>On July 30, 2025, the latch was removed in the 2 horizontal-sliding exit doors in the lobby.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 09/05/2025                                                                                         |  |                                                 |  |

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| K0222<br>SS = F                                                      | <p>Continued from page 2</p> <p>Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:</p> <p><b>CLINICAL NEEDS OR SECURITY THREAT LOCKING</b></p> <p>Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.</p> <p>18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6</p> <p><b>SPECIAL NEEDS LOCKING ARRANGEMENTS</b></p> <p>Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4</p> <p><b>DELAYED-EGRESS LOCKING ARRANGEMENTS</b></p> <p>Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p><b>ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS</b></p> <p>Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p><b>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS</b></p> | K0222                                                                  | <p>Continued from page 2</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The Administrator educated the <b>U.S. FOIA (b)(6)</b> that doors in a required means of egress need to be in accordance with NFPA 101:2012 Edition, Sections 7.2.1.6.1 and 19.2.2.2.4.</p> <p>Maintenance Director/Designee will ensure doors in a required means of egress are continuously maintained and free of obstructions as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately.</p> <p>The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Maintenance Director/Designee will present the inspection results to the Quality Assurance Performance Improvement (QAPI) committee monthly x 6 months.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> <p>The Date of Completion is September 5, 2025.</p> <p>The administrator is responsible for the implementation of the Plan of Correction.</p> |                                                                                                    |  |                                                 |  |

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| K0222<br>SS = F                                                      | <p>Continued from page 3</p> <p>Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews from 07/28/2025 to 7/30/2025 in the presence of the <b>U.S. FOIA (b)(6)</b>, it was determined that the facility failed to ensure that doors in a required means of egress were in accordance with NFPA 101:2012 Edition, Sections 7.2.1.6.1 and 19.2.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Observations on 7/29/2025 revealed that two of 2 horizontal-sliding exit doors in the lobby were equipped with a thumb turn latch.</p> <p>In interviews at the time, the <b>U.S. FOIA (b)(6)</b> confirmed the observations.</p> <p>The facility's <b>U.S. FOIA (b)(6)</b> was informed of the deficient practice at the Life Safety Code exit conference on 07/30/2025 at 12:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e)</p> | K0222                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                    |  |                                                 |  |
| K0225<br>SS = F                                                      | <p>Stairways and Smokeproof Enclosures</p> <p>CFR(s): NFPA 101</p> <p>Stairways and Smokeproof Enclosures</p> <p>Stairways and Smokeproof enclosures used as exits are in accordance with 7.2.</p> <p>18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews from 07/28/2025 to 7/30/2025 in the presence of the <b>U.S. FOIA (b)(6)</b>, it was determined that the facility failed to ensure that stairways and smokeproof enclosures used as exits were in accordance with NFPA 101:2012 Edition, Sections 7.2, 19.2.2.3 and</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | K0225                                                                  | <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>Vendor was contracted to inspect the 9th floor south side, 6th floor north and south, 3rd floor south side, 2nd floor south side to certify the fire rating. All doors passed the test and received updated fire labels.</p> <p>For Floor 2 north and south, the equipment was swapped for appropriate fire rating hardware.</p> <p>For Floor 1 south side, sign was switched from saying push door to saying pull door.</p> <p>Latching hardware was installed on floor 1 south side.</p> <p>How will other residents who may have the potential to be affected be identified?</p> |                                                                                                    |  | 09/05/2025                                      |  |

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 0...</b><br>B. WING                |  | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                    |  | (X5)<br>COMPLETION<br>DATE                      |  |
| K0225<br>SS = F                                                          | <p>Continued from page 4</p> <p>19.2.2.4. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Observations on 07/29/2025 from 9:50 AM to 12:59 PM revealed:The fire rated door assemblies to the stairway enclosures on floors 9 thru 1 all contained approximately 4-inch unprotected penetrations from previously removed hardware on the inside of the frames.The fire rated doors on Floor 9 Southside (SS), Floor 6 Northside (NS) and (SS), Floor 3 (SS), Floor 2 (SS) did not have a Fire rating label.Floor 2 (NS) and (SS) stairway enclosure doors were not equipped with fire rated hardware.Floor 1 (NS) stairway enclosure door was equipped with a delayed egress locking arrangement. The door was identified as the exit door from the stairway enclosure door by a photo-luminescent exit sign and was confirmed by the [U.S. FOIA (b)(6)] The door was provided with a sign that read "PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SEC". The door did not open in the direction of egress and required that the door be pulled to activate the delayed egress feature.Floor 1 (SS) stairway enclosure contained a pair of doors equipped with delayed egress locking arrangements. The pair of doors were not equipped with latching hardware. This absence of latching hardware would prevent the doors from closing and positive latching in the event of an emergency when the delayed egress device is de-energized by activation of the fire alarm system.In interviews at the time, the [U.S. FOIA (b)(6)] confirmed the observations.</p> <p>The facility's [U.S. FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 07/30/2025 at 12:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e)</p> | K0225                                                                  | <p>Continued from page 4</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The Administrator educated the [U.S. FOIA (b)(6)] that stairways and smokeproof enclosures used as exits need to be in accordance with NFPA 101:2012 Edition, Sections 7.2, 19.2.2.3 and 19.2.2.4.</p> <p>Maintenance Director/Designee will perform a monthly inspection and testing to ensure that all fire-rated doors are functioning properly and meet the required standards. The monthly inspection will include a comprehensive checklist to ensure that all doors are inspected for proper hardware, signage, and functionality. If any issues are discovered, they will be addressed and resolved immediately.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Maintenance Director/Designee will present the inspection results to the Quality Assurance Performance Improvement (QAPI) committee monthly x 6 months.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> <p>The Date of Completion is September 15, 2025.</p> |                                                                                                    |  |                                                 |  |
| K0293<br>SS = F                                                          | <p>Exit Signage</p> <p>CFR(s): NFPA 101</p> <p>Exit Signage</p> <p>2012 EXISTING</p> <p>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.</p> <p>19.2.10.1</p> <p>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | K0293                                                                  | <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>On July 30th, 2025, illuminated exit signs were ordered to be added above the egress side of the smoke barrier doors on floors 9 thru 3. The exit signs installation above the egress side of the smoke barrier doors on floors 9 thru 3 was completed August 11th 2025.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected by the deficient practice.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                    |  | 09/05/2025                                      |  |

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |  |                                                 |  |
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| K0293<br>SS = F                                                      | <p>Continued from page 5<br/>obvious.)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews from 07/28/2025 to 7/30/2025 in the presence of the <b>U.S. FOIA (b)(6)</b>, it was determined that the facility failed to ensure that exit signs were installed above doors through which the egress path leads in accordance with NFPA 101:2012 Edition, Section 7.10.1.2.2. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Observations on 07/29/2025 from 9:50 AM to 11:39 AM revealed that illuminated exit signs were not placed above the egress side of the smoke barrier doors on floors 9 thru 3.</p> <p>In interviews at the time, the <b>U.S. FOIA (b)(6)</b> confirmed the observations</p> <p>The facility's <b>U.S. FOIA (b)(6)</b> was informed of the deficient practice at the Life Safety Code exit conference on 07/30/2025 at 12:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e)</p> | K0293                                                                  | <p>Continued from page 5</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The Administrator educated the <b>U.S. FOIA (b)(6)</b> that exit signs need to be installed above doors through which the egress path leads in accordance with NFPA 101:2012 Edition, Section 7.10.1.2.2.</p> <p>Maintenance Director/Designee will ensure that exit signs are above doors through which the egress path leads in accordance with NFPA 101:2012 Edition, Section 7.10.1.2.2 as part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate. If any issues are discovered, they will be addressed and resolved immediately.</p> <p>The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Maintenance Director/Designee will present the inspection results to the Quality Assurance Performance Improvement (QAPI) committee monthly x 6 months.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> <p>The Date of Completion is September 5, 2025.</p> <p>The administrator is responsible for the implementation of the Plan of Correction.</p> |                                                                                                    |  |                                                 |  |
| K0321<br>SS = F                                                      | <p>Hazardous Areas - Enclosure</p> <p>CFR(s): NFPA 101</p> <p>Hazardous Areas - Enclosure</p> <p>Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | K0321                                                                  | <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>On July 30, 2025, the paper that was stuffed in the latch hole in the door frame located in the soiled linen room on floor 4 was removed. The door was tested and confirmed to self-latch.</p> <p>On July 30, 2025, the metal angle iron attached to a chain which prevents the laundry room door from closing</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                    |  | 09/05/2025                                      |  |

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| K0321<br>SS = F                                                      | <p>Continued from page 6<br/>areas shall be separated from other spaces by smoke<br/>resisting partitions and doors in accordance with 8.4.<br/>Doors shall be self-closing or automatic-closing and<br/>permitted to have nonrated or field-applied protective<br/>plates that do not exceed 48 inches from the bottom of<br/>the door.</p> <p>Describe the floor and zone locations of hazardous<br/>areas that are deficient in REMARKS.</p> <p>19.3.2.1, 19.3.5.9</p> <p>Area Automatic Sprinkler Separation N/A</p> <p>a. Boiler and Fuel-Fired Heater Rooms</p> <p>b. Laundries (larger than 100 square feet)</p> <p>c. Repair, Maintenance, and Paint Shops</p> <p>d. Soiled Linen Rooms (exceeding 64 gallons)</p> <p>e. Trash Collection Rooms<br/>(exceeding 64 gallons)</p> <p>f. Combustible Storage Rooms/Spaces<br/>(over 50 square feet)</p> <p>g. Laboratories (if classified as Severe<br/>Hazard - see K322)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews from 07/28/2025 to<br/>7/30/2025 in the presence of the [U.S. FOIA (b)(6)]<br/>[REDACTED], it was determined that<br/>the facility failed to ensure that hazardous areas were<br/>protected in accordance with NFPA 101:2012 Edition,<br/>Section 8.4, 19.3.2.1 and 19.3.5.9. This deficient<br/>practice had the potential to affect all residents and<br/>was evidenced by the following:</p> <p>An observation on 07/29/2025 at 11:26 AM revealed that<br/>the soiled linen room door on floor 4 did not<br/>self-close and positive latch when tested by the [U.S. FOIA (b)(6)].<br/>The latch hole in the door frame was stuffed with<br/>paper.</p> | K0321                                                                  | <p>Continued from page 6<br/>was removed and a new self-close latch was installed<br/>was installed on August 2nd 2025.</p> <p>How will other residents who may have the potential to<br/>be affected be identified?</p> <p>All residents have the potential to be affected by the<br/>deficient practice.</p> <p>What measures will be put into place or what systematic<br/>changes will be made to ensure that the deficient<br/>practice does not reoccur?</p> <p>The Administrator educated the [U.S. FOIA (b)(6)]<br/>that hazardous areas need to be protected by a fire<br/>barrier having 1-hour fire resistance rating or an<br/>automatic fire extinguishing system in accordance to NFPA<br/>101:2012 Edition, Section 8.4, 19.3.2.1 and<br/>19.3.5.9.</p> <p>Maintenance Director/Designee will ensure<br/>that hazardous areas are protected by a fire barrier<br/>having 1-hour fire resistance rating or an automatic<br/>fire extinguishing system in accordance to NFPA<br/>101:2012 Edition, Section 8.4, 19.3.2.1 and 19.3.5.9 as<br/>part of the facility's monthly Preventive Maintenance<br/>Program and document those inspection results as<br/>appropriate. If any issues are discovered, they will be<br/>addressed and resolved immediately.</p> <p>The Maintenance Supervisor/designee will review with<br/>the Administrator the inspection results. The<br/>Administrator will monitor adherence to the<br/>Preventative Maintenance schedule and the Preventative<br/>Maintenance is in place.</p> <p>How will the corrective action(s) be monitored to<br/>ensure the deficient practice will not reoccur and what<br/>QA program will be put into place?</p> <p>The Maintenance Director/Designee will present the<br/>inspection results to the Quality Assurance Performance<br/>Improvement (QAPI) committee monthly x 6 months.</p> <p>The QAPI Committee will make recommendations based upon<br/>the results of the audits.</p> <p>The QAPI Committee will recommend tapering and<br/>dissolution of audits once consistent compliance has<br/>been achieved.</p> <p>The Date of Completion is September 5, 2025.</p> |                                                                                                    |                            |                                                 |  |

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| K0321<br>SS = F                                                      | <p>Continued from page 7</p> <p>In an interview at the time, the [REDACTED] confirmed the observation and removed the paper. The door did not positive latch after removal of the impediment.</p> <p>An observation at 1:35 PM revealed that the laundry room door was being held open by a metal angle iron attached to a chain. This setup was being used instead of the proper armature plate. The metal angle iron was hooked onto a linen cart behind the door, which would prevent the door from automatically closing upon activation of the fire alarm system.</p> <p>In an interview at the time, the [REDACTED] confirmed the observation and had someone remove the metal angle iron.</p> <p>The facility's [REDACTED] was informed of the deficient practice at the Life Safety Code exit conference on 07/30/2025 at 12:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e)</p>                                            |                                                                        | K0321               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                                 |  |
| K0761<br>SS = F                                                      | <p>Maintenance, Inspection &amp; Testing - Doors</p> <p>CFR(s): NFPA 101</p> <p>Maintenance, Inspection &amp; Testing - Doors</p> <p>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.</p> <p>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.</p> <p>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.</p> <p>Written records of inspection and testing are maintained and are available for review.</p> <p>19.7.6, 8.3.3.1 (LSC)</p> <p>5.2, 5.2.3 (2010 NFPA 80)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on a record review, observations and interviews from 07/28/2025 to 07/30/2025, it was determined that</p> |                                                                        | K0761               | <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>On July 30, 2025, a new latch was ordered for the pair of exit doors on the south side stairway. The latch was installed on August 27, 2025.</p> <p>A new maintenance log was created to include this set of doors for annual inspection, testing and maintenance.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The Administrator educated the [REDACTED] that fire door assemblies need to be Inspected, Tested and Maintained annually by individuals that had an understanding of the operating components of the doors in accordance with NFPA 101:2012 Edition, Sections 7.2.1.15, 19.7.6, 8.3.3.1 and the minimum requirements of NFPA 80:2010 Edition, Sections 5.2.1 and 5.2.4.2 (1)</p> |  | 10/07/2025                                      |  |

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| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><b>315112</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 0...</b><br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                     |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |  | (X5)<br>COMPLETION<br>DATE                      |  |
| K0761<br>SS = F                                                      | <p>Continued from page 8</p> <p>the facility failed to ensure that fire door assemblies were Inspected, Tested and Maintained (ITM) annually by individuals that had an understanding of the operating components of the doors in accordance with NFPA 101:2012 Edition, Sections 7.2.1.15, 19.7.6, 8.3.3.1 and the minimum requirements of NFPA 80:2010 Edition, Section 5.2.1 and 5.2.4.2 (1) – (11). This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation on 07/30/2025 at 9:30 AM revealed that the Floor- 1 south side exit stairway enclosure was provided with a pair of doors equipped with delayed egress locking arrangements. The pair of doors were not equipped with latching hardware. This absence of latching hardware would prevent the doors from closing and positive latching in the event of an emergency when the delayed egress device is de-energized by activation of the fire alarm system.</p> <p>A record review of the annual inspection of swinging fire door assemblies revealed that this set of doors was not included in the inspection, testing and maintenance log.</p> <p>In an interview at the time, the [REDACTED] confirmed the observation and stated that they would call a locksmith or someone more qualified to ensure that all doors are inspected and working properly.</p> <p>The facility's [REDACTED] was informed of the deficient practice at the Life Safety Code exit conference on 07/30/2025 at 12:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e)</p> <p>NFPA 80</p> |                                                                     | K0761               | <p>Continued from page 8 – (11).</p> <p>Maintenance Director/Designee will ensure that all fire door assemblies are Inspected, Tested and Maintained annually and document those inspection results in the log. If any issues are discovered, they will be addressed and resolved immediately.</p> <p>The Maintenance Supervisor/designee will review with the Administrator the results. The Administrator will monitor adherence to the Preventative Maintenance schedule that is in place.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Maintenance Director/Designee will present the inspection results to the Quality Assurance Performance Improvement (QAPI) committee annually.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> <p>The Date of Completion is October 7th, 2025.</p> |  |                                                 |  |
| K0923<br>SS = F<br>Bldg. 01                                          | <p>Gas Equipment - Cylinder and Container Storage</p> <p>CFR(s): NFPA 101</p> <p>Gas Equipment - Cylinder and Container Storage</p> <p>Greater than or equal to 3,000 cubic feet</p> <p>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.</p> <p>&gt;300 but &lt;3,000 cubic feet</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     | K0923               | <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>On July 30, 2025, the base liquid units for the two residents on the [REDACTED] floor [REDACTED] and [REDACTED] were replaced with standard E-tanks.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected by the</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  | 09/05/2025                                      |  |

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| <b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><b>315112</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 0...</b><br>B. WING | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                     |                                                 |
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| K0923<br>SS = F<br><br>Bldg. 01                                      | <p>Continued from page 9</p> <p>Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating.</p> <p>Less than or equal to 300 cubic feet</p> <p>In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.</p> <p>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews from 07/28/2025 to 7/30/2025 in the presence of the U.S. FOIA (b)(6) [REDACTED] and the U.S. FOIA (b) (6) [REDACTED] it was determined that the facility failed to ensure that the storage of oxygen was in accordance with NFPA 101:2012 Edition, Section 19.3.2.4, 8.7 and NFPA 99:2012 Edition, Section 11.3. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation on 07/28/2025 at 12:35 PM revealed that a resident was hooked up to a portable base liquid unit in the resident activity lounge on the 2<sup>nd</sup> floor.</p> <p>In an interview at the time, the surveyor asked the U.S. FOIA (b)(6) [REDACTED]</p> | K0923                                                               | <p>Continued from page 9 deficient practice.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The Administrator educated the U.S. FOIA (b)(6) [REDACTED] that storage of oxygen need to be in accordance with NFPA 101:2012 Edition, Section 19.3.2.4, 8.7 and NFPA 99:2012 Edition, Section 11.3.</p> <p>As part of the facility's monthly Preventive Maintenance Program, the Maintenance Director/Designee will ensure that all oxygen cylinders are properly stored and that there are no longer any more oxygen cylinders of 300 cubic feet or more in service. If any issues are discovered, they will be addressed and resolved immediately.</p> <p>The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Maintenance Director/Designee will present the inspection results to the Quality Assurance Performance Improvement (QAPI) committee monthly x 6 months.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> <p>The Date of Completion is September 5, 2025.</p> |                                                                                     |                                                 |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTIONS                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 0...</b><br>B. WING                |  | (X3) DATE SURVEY COMPLETED<br><b>07/31/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                        |                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY) |                                                                                                    |  | (X5)<br>COMPLETION<br>DATE                      |  |
| K0923<br>SS = F<br>Bldg. 01                                          | <p>Continued from page 10</p> <p>if they knew the quantity of oxygen in cubic feet that the portable base liquid unit was capable of holding as there were no indications on the cylinder itself. The [U.S. FOIA (b)(6)] confirmed that a resident was actively being administered oxygen in the resident activity lounge and stated that they would contact their oxygen service provider to request the information.</p> <p>An observation on 07/29/2025 at 9:53 AM revealed that a base liquid unit was stored in resident room [NJ Ex Order 26.4(b)(1)] near the door.</p> <p>In an interview at the time, the [U.S. FOIA (b)(6)] confirmed the observation.</p> <p>A documentation review on 07/29/2025 revealed that the base liquid unit was identified as holding 900 cubic feet of oxygen on the document titled "Oxygen Safety Notice" that was provided by the oxygen service provider and given to the surveyor by the [U.S. FOIA (b)(6)].</p> <p>In an interview on 7/30/2025 the surveyor asked the [U.S. FOIA (b)(6)] if it was standard practice at the facility, to have a resident hooked up to a portable base liquid unit. The [U.S. FOIA (b)(6)] stated "yes" "it is done for 2 residents, rooms [NJ Ex Order 26.4(b)(1)] and [NJ Ex Order 26.4(b)(1)] bed [NJ Ex Order 26.4(b)(1)]. "They are both hooked up to base liquid units because they are [NJ Ex Order 26.4(b)(1)]". They use the larger liquid based unit for convenience because the standard E-tanks [NJ Ex Order 26.4(b)(1)] and they "would then have to [NJ Ex Order 26.4(b)(1)]".</p> <p>An observation at 9:02 AM revealed that the resident from room [NJ Ex Order 26.4(b)(1)] bed [NJ Ex Order 26.4(b)(1)] was actively being administered [NJ Ex Order 26.4(b)(1)] in the exit access corridor near the exit stairway enclosure on the [NJ Ex Order 26.4(b)(1)] floor.</p> <p>In an interview at the time, the [U.S. FOIA (b)(6)] confirmed the observation.</p> <p>The facility's [U.S. FOIA (b)(6)] was informed of the deficient practice at the Life Safety Code exit conference on 07/30/2025 at 12:00 PM.</p> <p>N.J.A.C 8:39-31.2 (e)</p> | K0923                                                                  |                                                                                                                          |                                                                                                    |  |                                                 |  |

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                              |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |                                                                                                                          |                                                 |                            |
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| K0923<br>SS = F<br><br>Bldg. 01                                      | Continued from page 11<br>NFPA 99                                                                                            |                                                                        |  | K0923                                                                                              |                                                                                                                          |                                                 |                            |

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                   |                                                                        |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                       |  |                                                 |  |
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| E0000                                                                | Initial Comments<br><br>An Emergency Preparedness Survey was conducted by the New Jersey Department of Health (NJDOH) from 07/28/25 to 07/30/25. Hudson View Health Care Center was found to be in COMPLIANCE with 42 CFR 483.73. |                                                                        | E0000               |                                                                                                                          |  | 09/05/2025                                      |  |

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

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| K0000                                                                | <p>INITIAL COMMENTS</p> <p>An on-site revisit was conducted on 11/12/2025 to verify the facility's Plan of Correction for the 7/31/2025 Recertification survey. The facility was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy.</p> <p>Hudson View contains a total of 11 floors.</p> <p>Floor 10 is for physical therapy....Currently being renovated.</p> <p>Floors 9 thru 3 are resident room floors. Each floor contains 2 smoke compartments and 39 resident rooms.</p> <p>Floor 2 contains the Kitchen, Staff lounge and Nursing/Business offices.</p> <p>Floor 1 contains the Lobby/ parking garage and Administrative offices.</p> <p>Ground floor contains the boiler room/laundry room/storage rooms and the emergency generator.</p> <p>Hudson View Health Care Center is a 10-story building with a basement that was built in the 1960's. It is composed of Type I protected construction. The facility is divided into 14 - smoke zones. The percentage of the building served by the emergency generator is not known per the <b>U.S. FOIA (b)(6)</b> Documentation provided by the <b>U.S. FO</b> indicated that the HVAC system, walk in fridges and freezers, fire pumps and the PTAC units in residents' rooms are not hooked up to the emergency generator. The current occupied beds are 263 of 273.</p> |                                                                        |  | K0000                                                                                              |                                                                                                                                                                                                                                                                                              |                                                 | 12/11/2025                 |
| K0211<br>SS = F                                                      | <p>Means of Egress - General</p> <p>CFR(s): NFPA 101</p> <p>Means of Egress - General</p> <p>Aisles, passageways, corridors, exit discharges, exit</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |  | K0211                                                                                              | <p>What corrective action was accomplished for the resident found to have been affected by the deficient practice?</p> <p>The facility immediately removed all trip hazards and contacted their vendor come in to repair the grate in the center of the walkway of the walkway to ensure</p> |                                                 | 12/12/2025                 |

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

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 0...</b><br>B. WING                |  | (X3) DATE SURVEY COMPLETED<br><b>11/12/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |  |                                                 |  |
| (X4) ID<br>PREFIX<br>TAG                                             | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE<br>APPROPRIATE DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                    |  | (X5)<br>COMPLETION<br>DATE                      |  |
| K0211<br>SS = F                                                      | <p>Continued from page 1<br/>locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.</p> <p>18.2.1, 19.2.1, 7.1.10.1</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interview on 11/12/2025 in the presence of the <b>U.S. FOIA (b)(6)</b>, it was determined that the facility failed to ensure that the exit discharges, exit locations and accesses were in accordance with NFPA 101:20212 Edition, Sections 19.2.1 and 7.7.1.1. This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation on 11/12/2025 at 10:10 AM in the presence of the <b>U.S. FOIA (b)(6)</b> revealed that exit access to a public way was obstructed by multiple trip hazards, in-complete welding of safety grates, and a 5-inch step down to the exit way. Three strips of yellow caution tape were in place at the end of the egress walkway blocking final exit.</p> <p>In an interview at the time, the <b>U.S. FOIA (b)(6)</b> confirmed the observation.</p> <p>The initial findings from 7/30/2025 Recertification Survey of metal exhaust ductwork extending through metal grates directly in the center of the exit access pathway had been resolved creating a 36-inch pathway. The correction had not been completed to the metal grates. The <b>U.S. FOIA (b)(6)</b> stated that they were waiting for a welder to come and complete repairs to the grating as the moving of the ductwork had created large openings that a person could trip or fall upon. Plywood, strandboard and 2x4 material had been wired to the grating to cover the openings and provide a pathway. The boards created a trip hazard and a 5-inch step down within the walkway.</p> <p>The facilities POC completion date was marked as 09/25/2025 and stated that the <b>U.S. FOIA (b)(6)</b> /Designee will ensure means of egress are continuously maintained and free of obstructions.</p> | K0211                                                                  | <p>Continued from page 1<br/>proper means of egress. The vendor came in 12/12/2025 and repaired this.</p> <p>How will other residents who may have the potential to be affected be identified?</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not reoccur?</p> <p>The Administrator educated the <b>U.S. FOIA (b)(6)</b> that exit discharges, exit locations and accesses need to be in accordance with NFPA 101:2012 Edition, Sections 19.2.1 and 7.7.1.1.</p> <p>Maintenance Director/Designee will ensure means of egress are continuously maintained and free of obstructions as a part of the facility's monthly Preventive Maintenance Program and document those inspection results as appropriate.</p> <p>If any issues are discovered, they will be addressed and resolved immediately.</p> <p>The Maintenance Supervisor/designee will review with the Administrator the inspection results. The Administrator will monitor adherence to the Preventative Maintenance schedule and the Preventative Maintenance is in place.</p> <p>How will the corrective action(s) be monitored to ensure the deficient practice will not reoccur and what QA program will be put into place?</p> <p>The Maintenance Director/Designee will present the inspection results to the Quality Assurance Performance Improvement (QAPI) committee monthly x 6 months.</p> <p>The QAPI Committee will make recommendations based upon the results of the audits.</p> <p>The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.</p> <p>The Date of Completion is December 12, 2025</p> |                                                                                                    |  |                                                 |  |

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| <b>STATEMENT OF DEFICIENCIES<br/>AND PLAN OF CORRECTIONS</b>         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><b>315112</b> |                     | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 0...</b><br>B. WING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | (X3) DATE SURVEY COMPLETED<br><b>11/12/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                        |                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                 |  |
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| K0211<br>SS = F                                                      | Continued from page 2<br><br>The facility's <b>U.S. FOIA (b)(6)</b> were notified of the deficient practice during the Life Safety Code exit conference at 12 PM. The facility's <b>U.S. FOIA (b)(6)</b> was not in the building at the time of exit.<br><br>NJAC 8:39-31.2(e)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                        | K0211               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |  |                                                 |  |
| K0761<br>SS = F<br>Bldg. 01                                          | Maintenance, Inspection & Testing - Doors<br><br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br><br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br><br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br><br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br><br>Written records of inspection and testing are maintained and are available for review.<br><br>19.7.6, 8.3.3.1 (LSC)<br><br>5.2, 5.2.3 (2010 NFPA 80)<br><br>This STANDARD is NOT MET as evidenced by:<br><br>Based on a record review and interviews on 11/12/2025 in the presence of the <b>U.S. FOIA (b)(6)</b> it was determined that the facility failed to ensure that fire door assemblies were inspected, tested and maintained (ITM) annually in accordance with NFPA 101:2012 Edition, Sections 7.2.1.15 and the minimum requirements of NFPA 80:2010 Edition, Section 5.2.1 and 5.2.4.2 (1) - (11). This deficient practice had the potential to affect all residents and was evidenced by the following:<br><br>During the on-site Life Safety Revisit, an observation at 9:52 AM revealed that the Floor 1 south side exit stairway enclosure had new latching hardware installed to both exit doors. When the <b>U.S. FOIA (b)(6)</b> attempted to open the doors after 15 seconds in egress alarm, the doors would |                                                                        | K0761               | 1. How the deficient practice was corrected for the affected doors:<br><br>The facility immediately removed the metal strip interfering with the left-hand door release mechanism. The paired exit doors were adjusted and tested to ensure both doors release and open simultaneously upon alarm activation and function properly during normal egress conditions.<br><br>2. How residents at risk for the same issue were identified:<br><br>All residents have the potential to be affected by the deficient practice<br><br>3. What systemic changes were made to prevent recurrence:<br><br>The facility reinforced its fire door inspection and testing process to ensure that any hardware replacement or modification is followed by functional testing prior to use. Door functionality verification has been added to the post-installation checklist for all fire door and exit hardware work.<br><br>4. How ongoing compliance will be monitored:<br><br>The Maintenance Director or designee will conduct *quarterly operational checks* of all fire door assemblies and exit doors, in addition to required annual NFPA 80 inspections. Results will be documented, and any deficiencies will be corrected promptly with re-testing completed.<br><br>5. Date of compliance:<br><br>12/12/2025 |  | 12/12/2025                                      |  |

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |                                                                                                                          |                                                 |                            |
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| K0761<br>SS = F<br><br>Bldg. 01                                      | <p>Continued from page 3</p> <p>not open. The [REDACTED] then attempted to open the doors after inputting the release code and only the right-hand door would open upon the magnetic lock releasing. Only after the right-hand door was opened would the left-hand door then release when the latching hardware was pushed.</p> <p>In an interview at the time, the [REDACTED] confirmed the observations.</p> <p>The facility's [REDACTED] U.S. FOIA (b) (6) [REDACTED] were informed of the deficient practice during the Life Safety Code exit conference at 12 PM. The facility's [REDACTED] U.S. FOIA (b)(6) [REDACTED] was not in the building at the time of exit.</p> <p>NJAC 8:39-31.1(c), 31.2(e)</p> <p>NFPA 80</p> |                                                                        |  | K0761                                                                                              |                                                                                                                          |                                                 |                            |

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| NAME OF PROVIDER OR SUPPLIER<br><b>HUDSONVIEW HEALTH CARE CENTER</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                        |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>9020 WALL STREET , NORTH BERGEN, New Jersey, 07047</b> |                                                                                                                          |                                                 |                            |
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| K0000<br><br>Bldg. 01                                                | <b>INITIAL COMMENTS</b><br><br>An offsite/desk review of the facility's Plan of Correction was conducted on 1/5/2026 in relation to the 11/12/2025 onsite revisit associated with the 7/31/2025 Life Safety Code survey. The facility was found to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. |                                                                        |  | K0000                                                                                              |                                                                                                                          |                                                 |                            |

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

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