STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315112	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions on behalf of the New Jersey Department of Health. Complaint #: NJ154899, NJ161076, NJ161430, NJ161969, NJ163262, NJ163355, NJ165405, and NJ165675 Survey Dates: 01/07/24 to 01/20/24 Survey Census: 253 Sample Size: 55 Supplemental Residents: 0 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 604		3/8/24

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

Electronically Signed | 02/01/2024

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F 604	Continued From page 1 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure that residents were free from the use of NJ Exec Order 26.4b1 for one (Resident (R)209) out of two residents reviewed for NJ Exec Order 26.4b [redacted] out of a total sample of 55 residents. Findings include: Review of R209's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed R209 was admitted to the facility on NJ Exec Order 26.4b with diagnoses including NJ Exec Order 26.4b1 [redacted] Review of R209's annual "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b, revealed she scored NJ Exec [redacted] out of 15 on the "Brief Interview for Mental Status (BIMS),"	F 604	1. Resident #209's NJ Exec Order 26.4b [redacted] were removed. Resident 209's NJ Exec Order 26 [redacted] assessment was reviewed and updated. 2. Residents using side rails have the potential to be affected by the alleged deficient practice. Side rail assessments for all residents were reviewed and updated as needed. No other residents were identified as affected. 3. ADON initiated a re-education to all nursing staff regarding the proper use of side rails including the need for side rail assessment and obtaining a side rail consent. ADON also initiated re-education on facility's policy on having a Restraint-free environment. These education will be provided to	

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F 604	Continued From page 2 indicating R209 was NJ Exec Order 26.4b1 Further review revealed NJ Exec Order 26.4b were not listed as being in use for R209. Review of R209's "Care Plan," located under the "Care Plan" tab of the EMR and dated NJ Exec Order 26.4b, revealed R209 was using NJ Exec Order 26.4b1 and was at risk for NJ Exec Order 26.4b1 and NJ Exec Orde. Interventions in place were to ensure NJ Exec Order 26.4b1 and evaluate continuous need for NJ Exec Order 26.4b. Further review revealed R209 was care planned for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 as evidenced by NJ Exec Order 26.4b1 of continuously NJ Exec Order 26.4b1 Review of R209's "Quarterly Nursing Assessment" located under the "Observations" tab in the EMR and dated NJ Exec Order 26.4b revealed R209 scored a NJ Ex on the NJ Exec Order 26.4b1, which indicated R209 was a NJ Exec Order 26.4b1. Further review revealed R209 was currently using NJ Exec O for NJ Exec Order 26 and NJ Exec Order 26.4b1 and wants NJ Exec O at this time, but NJ Exec Order 26.4b do not prohibit R209's NJ Exec Order 26 or NJ Exec Order 26. of NJ Exec Order 26.4b1 and are not a NJ Exec Order 26.4b Review of R209's "Physician's Orders" located under the "Orders" tab in the EMR, dated NJ Exec Order 26.4b revealed R209 may have NJ Exec Order 26.4b1 for NJ Exec Order 26.4b1 request. During observations on NJ Exec Order 26.4b at 10:26 AM and on NJ Exec Order 26.4b at 1:57 PM, R209 was lying in bed with NJ Exec Order 26.4b1 in place on NJ Exec Order 26.4b1 of the bed. During an interview on 01/09/24 at 12:04 PM, the NJ Exec Order 26.4b1 Director stated R209 required staff's assistance with NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and upon discharge from NJ Exec Order 26 in	F 604	newly-hired licensed nurses and Certified Nurse Assistants (CNA), and to all licensed nurses and CNA's annually and as needed. 4. Director of Nursing or ADON will conduct audits to ensure that residents are free from unnecessary use of side rails on 5 residents using side rails/week for 4 weeks and then 5 residents monthly for 3 months to ensure continued use is warranted. Results of the audits will be reported to the QA committee monthly. The QAPI Committee will make recommendations based upon the results of the audits. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. 5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	

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F 604	Continued From page 3	F 604		

NJ Exec Order 26.4b1, R209 still required staff prompting and queuing to use NJ Exec Order 26.4b1. The NJ Exec Order 26.4b1 Director stated that without staff being present and prompting, R209 would be NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 with intent due to the resident's NJ Exec Order 26.4b1 The NJ Exec Order 26.4b1 Director stated NJ Exec Order 26.4b1 were up for NJ Exec Order 26.4b1 risk, but she was NJ Exec Order 26.4b1 should NJ Exec Order 26.4b1 when R209 was in bed when staff were not in the room helping the resident.

During an interview on 01/09/24 at 12:25 PM, Certified Nursing Assistant (CNA)6 stated R209 was NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 herself in bed and that staff needed to help with that. CNA6 stated the NJ Exec Order 26.4b1 were in place to keep R209 from NJ Exec Order 26.4b1. CNA6 stated R209 was NJ Exec Order 26.4b1 without staff assistance and that R209 was unable to put the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 by herself. CNA6 stated the NJ Exec Order 26.4b1 were always kept up whenever R209 was in bed.

During an interview on 01/09/24 at 1:24 PM, Registered Nurse/Unit Manager (RN)4 stated NJ Exec Order 26.4b1 were used for NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 and helped with providing care. RN4 stated R209 required cuing from staff to use the NJ Exec Order 26.4b1 and was NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 due to R209's NJ Exec Order 26.4b1 and R209 was NJ Exec Order 26.4b1 without staff assistance. RN4 stated she thought that R209 NJ Exec Order 26.4b1 and get around the NJ Exec Order 26.4b1 but that staff kept an eye on her. RN4 stated she was unsure why the NJ Exec Order 26.4b1 were kept up whenever R209 was in bed since R209 was only able to use them with staff prompting. RN4 stated the family wanted the NJ Exec Order 26.4b1 up and that staff went over the risks and

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F 604	Continued From page 4	F 604		

benefits with the family when the consent was signed.

During an interview on 01/10/24 at 1:25 PM, the U.S. FOIA (b) (6) stated when NJ Exec Order 26.4b were used a NJ Exec Order 2 assessment was completed and staff took into consideration a resident's NJ Exec Order 26.4b1 and overall, activities of daily living (ADLs) functionality and what type of ADL assistance a resident required to determine if the resident needed a NJ Exec Order 26 to NJ Exec O or NJ Exec Order 26.4b1 and to help them get up or when staff were providing care. The U.S. FOIA stated staff tried removing NJ Exec Order 26.4b before but there was an increase in NJ Exec and families requested the NJ Exec Order 26 be used. The U.S. FOIA stated they discussed risk versus benefits, but some families insisted on residents having them. The U.S. FOIA was unable to answer if a NJ Exec Order 26 should be down when staff were not in the room providing care. But she did state the facility recognized the need to update the NJ Exec Order 26 assessments and she knew some of the assessments had been not updated. The U.S. FOIA stated she felt R209 used the NJ Exec Order 26.4b as an NJ Exec Order 26.

A review of the facilities policy titled "Restraint Free Environment," revised 07/23 indicated, "Each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of

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F 604	Continued From page 5 movement or normal access to one's body. Physical restraints may include but are not limited to using side rails to keep resident from voluntarily getting out of bed." NJAC 8:39-4.1(a)6 NJAC 8:39-27.1(c)	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		3/8/24

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F 609	Continued From page 6 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and facility policy review, the facility failed to ensure that NJ Exec Order 26.4b1 observed on a resident's NJ Exec were reported to the state survey agency for one (Resident (R)83) out of three residents reviewed for NJ Exec Orde and NJ Exec Order 2 out of a total sample of 55 residents. Findings include: Review of R83's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R83 was initially admitted to the facility on NJ Exec Order 26.4b and was readmitted on NJ Exec Order 26.4b with diagnoses including NJ Exec Order 26.4b and NJ Exec Order 26.4b1. Review of R83's Quarterly "Minimum Data Set (MDS)" assessment located under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b, revealed R83 scored [redacted] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating R83 was NJ Exec Order 26.4b1 [redacted]. Further review revealed R83's NJ Exec Order 26.4b1 and required the use of an NJ Exec Order 26.4b1. Review of R83's "Care Plan," located under the "Care Plan" tab of the EMR, dated NJ Exec Order 26.4b, revealed, "The resident was at risk for NJ Exec Order 26.4b [redacted] related to NJ Exec Order [redacted]." Review of R83's "Health Status Note" located under the "Progress Notes" tab in the EMR, dated NJ Exec Order 26.4b revealed notified by CNA that R83 had	F 609	1. A NJ Exec Order 26.4b1 [redacted] follow-up was done by the Social Worker on Resident 83. NJ Exec O [redacted] was identified. 2. All residents in the facility have the potential to be effected by this deficient practice. An audit which consisted of interviewing all alert and oriented residents to identify any allegations of abuse and neglect or concerns with care/treatment from staff was initiated to ensure all allegations of abuse and neglect have been reported timely to the administrator/designee and appropriate state agencies. 3. Vice President of Clinical Services provided training to US FOIA (b)(6) to ensure all allegations of abuse and neglect have been reported timely to the administrator/designee and appropriate state agencies. ADON initiated a re-education to all staff regarding the facility's policy on Abuse, Neglect and Exploitation, in particular, as it relates to the reporting of any allegations of abuse, neglect exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. 4. The DON/Designee will conduct an audit every end of each shift daily, to ensure no alleged abuse complaints from resident/family/responsible party are missed or unreported during the shift. Results of the audits will be reported to the QA committee monthly. The QAPI Committee will make	

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F 609	Continued From page 7 NJ Exec Order 26.4b1 on the NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 . Review of R83's "NJ Exec Order 26.4b1 Report" dated NJ Exec Order 26.4b, indicated a NJ Exec Order 26.4b1 on NJ Exec Order 26.4b with the physician, responsible party, and supervisor notified. Review of "Facility Incident/Accident Report" dated NJ Exec Order 26.4 revealed, possible contributing factors were R83 had a NJ Exec Order 26.4b1, required NJ Exec Order 26.4b1, and NJ Exec Order 26.4b1. Further review of this incident report revealed R83 was interviewed and said she NJ Exec Order 26.4b1 and NJ Exec Order 26 more easily. During an interview on 01/10/24 at 9:05 AM, Licensed Practical Nurse (LPN)2 stated she observed NJ Exec Order 2 on R83's NJ Exec and immediately reported it to the Registered Nurse (RN)5. During an interview on 01/10/24 at 9:37 AM, Certified Nursing Assistant (CNA)9 stated she observed the NJ Exec Order 2 on R83's NJ Exec while providing morning care and she informed the nurse immediately. During an interview on 01/10/24 at 10:40 AM, Family Member (FM)2 stated she did not remember staff notifying her about any NJ Exec Order 26.4b1 being discovered on R83 NJ Exec on NJ Exec Order 26.4b and she was not asked to NJ Exec Order 26. for staff so they could interview R83 about how the NJ Exec Order 2 occurred. FM2 stated R83 was unable to state how the NJ Exec Order 2 occurred. An interview was conducted on 01/10/24 at 1:39 PM with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) The U.S. FOIA stated after an incident,	F 609	recommendations based upon the results of the audits. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.	

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F 609	Continued From page 8 staff would assess any type of [NJ Exec Orde] interview staff and residents, and look at residents' medications. The [U.S. FOIA] stated if there is an [NJ Exec Ord] from NJ Exec Order 26.4b1, they report it to the state survey agency and notify the physician, family, complete an investigation, and update the care plan. The [U.S. FOIA] stated that this incident was not reported but there was an incident report done by RN5. A review of the facility policy titled "Abuse, Neglect and Exploitation," revised 06/09/23 revealed "Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals." The policy further revealed, "The Abuse coordinator in the facility is the Director of Nursing, Administrator, or facility appointed designee. Report allegations or suspected abuse, neglect, or exploitation immediately to the Administrator, other Officials in accordance with State Law and the State Survey and Certification agency through established procedures." NJAC 8:39-9.4(f)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		3/8/24

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F 610	Continued From page 9 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and facility policy review the facility failed to ensure that NJ Exec Order 26.4b1 observed on a resident's NJ Exec Order 2 were thoroughly investigated for one (Resident (R)83) out of three residents reviewed for NJ Exec Orde and NJ Exec Order 2 out of a total sample of 55 residents. Findings include: Review of R83's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR) revealed R83 was initially admitted to the facility on NJ Exec Order 26.4b and was readmitted on NJ Exec Order 26.4b with diagnoses including NJ Exec Order 26.4b and NJ Exec Order 26.4b1. Review of R83's Quarterly "Minimum Data Set (MDS)" assessment under the "MDS" tab of the EMR, with an Assessment Reference Date (ARD)	F 610	1. Resident 83 was interviewed by the Social Worker and NJ Exec Order 26.4b1 was identified. 2. All residents in the facility have the potential to be affected by this deficient practice. 3. Vice President of Clinical Services provided training to US FOIA (b)(6) regarding conducting a thorough investigation of allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property. Administrator initiated a re-education to all staff regarding their role in ensuring that when resident events occur, they are accurately reported, investigated, documented and necessary interventions are identified and implemented. These education will be provided to	

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F 610	Continued From page 10 of [redacted], revealed R83 scored [redacted] out of 15 on the "Brief Interview for Mental Status (BIMS)," indicating R83 was [redacted] Review of R83's "Health Status Note" located under the "Progress Notes" tab in the EMR and dated [redacted] revealed R83 had [redacted] on the [redacted]. Review of R83's [redacted] Report" dated [redacted] revealed a [redacted] on [redacted] and physician, responsible party, and supervisor notified. New intervention to prevent recurrence was staff were educated regarding [redacted] and care. Review of "Facility Incident/Accident Report" dated [redacted] revealed, possible contributing factors were R83 had a [redacted] Further review revealed R83 was interviewed and said she took [redacted] and [redacted] more easily. Further review revealed statements by Certified Nursing Assistant (CNA)9 who discovered the [redacted] Licensed Practical Nurse (LPN)2 to whom CNA9 reported the [redacted] and RN5 who filled out the report. Further review revealed no additional staff or residents were interviewed. During an interview on 01/10/24 at 9:05 AM, LPN2 stated she observed [redacted] on R83's [redacted] and immediately reported it to RN5. LPN2 stated she did not remember completing a statement regarding R83's [redacted] or being interviewed by staff. During an interview on 01/10/24 at 9:37 AM,	F 610	newly-hired staff and to all staff annually and as needed. 4. Administrator/DON will conduct audits to ensure that all resident events are accurately investigated. Results of the audits will be reported to the QA committee monthly. The QAPI Committee will make recommendations based upon the results of the audits. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. 5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	

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F 610	Continued From page 11	F 610		

CNA9 stated she observed the [NJ Exec Order 2] on R83's [NJ Exec] and informed the nurse immediately. CNA9 stated she did not remember completing a statement regarding R83's [NJ Exec Order 2] or being interviewed by staff.

During an observation and interview on 01/10/24 at 10:40 AM, Family Member (FM)2 stated she did not remember staff notifying her about any [NJ Exec Order 26.4b1] being discovered on R83 [NJ Exec] on [NJ Exec Order 26.4] and she was not asked to [NJ Exec Order 26.] for staff so they could interview R83 about how the [NJ Exec Order 2] occurred. FM #1 stated R83 was [NJ Exec Order 2] occurred.

An interview was conducted on 01/10/24 at 1:39 PM with the U.S. FOIA (b) (6)) and the U.S. FOIA (b) (6) The [U.S. FOIA] stated after an incident, staff would assess any type of [NJ Exec Orde] interview staff and residents, and look at residents' medications. The [U.S. FOIA] stated if there was still an NJ Exec Order 26.4b1 , they report it to the state survey agency and notify the physician, family, complete an investigation, and update the care plan. The [U.S. FOIA] stated RN5 wrote in the report that she interviewed R83 and that a family member was used at times to [NJ Exec Order 26.] but she did not know who RN5 used to [NJ Exec Order 26.] for R83. The [U.S. FOIA] said she felt it was investigated since RN5 stated she interviewed R83 and there was [NJ Exec Order 26.4b1].

A review of the facility policy titled "Abuse, Neglect and Exploitation," revised 06/09/23 revealed "Each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or

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F 610	Continued From page 12	F 610		

chemical restraint not required to treat the resident's medical symptoms. Residents must not be subject to abuse by anyone, including, but not limited to; facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals." Further review of the policy revealed, "Investigation of Alleged Abuse, Neglect and Exploitation. - When suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur, an investigation is immediately warranted. Once the resident is cared for and initial reporting has occurred, an investigation should be conducted. Components of an investigation may include Interview the involved resident, if possible, and document all responses. If a resident is cognitively impaired, interview the resident several times to compare responses. If there is no discernible response from the resident, or if the resident's response is incongruent with that of a reasonable person, interview the resident's family, responsible parties, or other individuals involved in the resident's life to gather how he/she believes the resident would react to the incident. Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements, according to appropriate policies. All statements should be signed and dated by the person making the statement. Document the entire investigation chronologically."

NJAC 8:39-4.1(a)5
NJAC 8:39-9.4(f)
NJAC 8:39-27.1(a)

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F 637	Continued From page 13	F 637		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the RAI (Resident Assessment Instrument) manual, the facility failed to complete a NJ Exec Order 26.4b1 [redacted] one of one resident (Resident (R) 109) reviewed for NJ Exec Order 26.4b1 [redacted] out of a total sample of 55 residents after R109 was placed on NJ Exec Order 26 care. Findings include: Review of R109's "Face Sheet," located in the electronic medical record (EMR) under the "Profile" tab, revealed R109 was admitted to the facility on NJ Exec Order 26.4b with diagnoses that included NJ Exec Order 26.4b1 Review of R109's NJ Exec Order 26.4b1 "Minimum Data Set (MDS) located under the "RAI" tab of the EMR, with an Assessment Reference Date (ARD) of NJ Exec Order 26.4b revealed that it was still in progress. R109 was admitted to NJ Exec Order 26	F 637	1. The NJ Exec Order 26.4b1 assessment (SCSA) for Resident 109 was completed by the ADON on NJ Exec Order 26 and was transmitted by the MDS Coordinator on NJ Exec Order 26 2. An audit of all SCSA in the last 30 days was initiated by MDS Coordinator on 1/10/24 to ensure that all assessments were completed timely. 3. MDS Assessors and US FOIA (b) [redacted] were educated by the Regional VP of Clinical Reimbursement on completing and transmitting resident assessments. 4. The MDS Coordinator will audit 3 SCSA monthly for 3 months. a) MDS Coordinator will report the	3/8/24

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F 637	Continued From page 14 NJ Exec Order 26.4b . Interview on 01/09/24 at 11:15 AM, Licensed Practical Nurse (LPN)1 stated, "There was a NJ Exec Order 26.4b1 completed for NJ Exec Order 26.4b due to NJ Exec Order 26.4b1 and [R109's] NJ Exec Order 26.4b1 " LPN1 stated that the NJ Exec Order 26.4b1 "MDS" was completed on NJ Exec Order 26.4b. Interview on 01/09/24 at 11:22 AM, the U.S. FOIA (b) (6)) stated "A NJ Exec Order 26.4b1 was completed on NJ Exec Order 26.4b." During an interview on 01/10/24 at 8:50 AM, the U.S. FOIA (b) (6)) stated that a NJ Exec Order 26.4b1 was not completed and was in progress. The U.S. FOIA (b) (6) stated, "I still have days to complete and send the data." During a follow-up interview on 01/10/24 at 1:21 PM, the U.S. FOIA (b) (6) stated that after review of the RAI for NJ Exec Order 26.4b1, the NJ Exec Order 26.4b1 MDS was overdue for R109. Review of the RAI manual indicated, " ...An significant change in status (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place. A Medicare-certified hospice	F 637	findings of the audits and reviews to the Quality Assurance and Performance Committee for any additional monitoring or modification of this plan monthly for 3 months. b) The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. 5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	

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F 637	Continued From page 15 must conduct an assessment at the initiation of its services. This is an appropriate time for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and services to assist the resident in achieving his/her highest practicable well-being at whatever stage of the disease process the resident is experiencing ..." NJAC 8:39-11.2(i)	F 637		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility	F 644	1. Resident 108 [redacted] was updated	3/8/24

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F 644	Continued From page 16 policy review, the facility failed to ensure residents with newly NJ Exec Order 26.4b1 was referred for a NJ Exec Order 26.4b1 evaluation for one of three sampled residents (Resident (R) 108) reviewed for NJ Exec Order 26.4b. R108 received a NJ Exec Order 26.4b1 diagnosis after admission to the facility; however, the resident was never referred for a NJ Exec Order 26.4b1. This failure had the potential to NJ Exec Order 26.4b1 the resident's NJ Exec Order 2 and NJ Exec Order 26.4b1 Findings include: Review of R108's undated "Face Sheet," provided by the facility, indicated R108 was admitted to the facility on NJ Exec Order 26.4b1. Review of the "Face Sheet" also revealed an active diagnosis of NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b Review of R108's "NJ Exec Order 26.4b1 dated NJ Exec Order 26.4b, provided by the U.S. FOIA (b) (6)) indicated NJ Exec Order 26.4b1 or NJ Exec Order 26.4b of a NJ Exec Order 26.4b1. Review of R108's annual "Minimum Data Set (MDS)," with an assessment reference date (ARD) of NJ Exec Order 26.4b, located in the resident's electronic medical record (EMR) under the "MDS" tab revealed the following active diagnoses: NJ Exec Order 26.4b1 During an interview on 01/19/24 at 3:45 PM, the U.S. FOIA (b) (6)) stated he should have reported a NJ Exec Order 26.4b1 in R108's condition to the state-designated NJ Exec Order 26.4b1 or NJ Exec Order 26.4b1 authority for a NJ Exec Order 2 of	F 644	and will be referred for a NJ Exec Order 2 evaluation. 2. PASRR's for residents with newly evident or possible serious mental disorder, intellectual disability (ID) or a related condition were audited for accuracy related to diagnoses and medications. Each resident that needs an updated PASRR will be referred for a PASRR Level II evaluation. 3. Administrator conducted an in-service to all Social Workers regarding referring all residents with newly evident or possible serious mental disorder, ID, or a related condition for level II resident review to the state-designated mental health or ID authority for a change of mental status. ADON initiated an in-service to all licensed nurses to notify Nursing Management or Social Worker for any resident that receives a new serious mental disorder diagnosis. 4. Social Services will conduct audits of PASRRs of 5 residents/weekly x 4 weeks and then 5 residents monthly for 3 months to ensure accuracy of PASSR. Results of the audits will be reported to the QA committee monthly. The QAPI Committee will make recommendations based upon the results of the audits. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved.	

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F 644	Continued From page 17 NJ Exec Order 26.4b1 Review of the facility's policy titled "Resident Assessment-Coordination with PASARR Program," dated January 2023, indicated "This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs." The policy also stipulated that "all applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules ..." NJAC 8:39-40.3(d)	F 644	5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to	F 692		3/8/24

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F 692	Continued From page 18 maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review, and policy review, the facility failed to ensure weekly [redacted] were ordered and/or obtained after a [redacted] for one (Resident (R) 46) of five reviewed for [redacted] out of a total sample of 55 residents. The facility failed to [redacted] the resident weekly for the [redacted] as directed by the Registered [redacted]. Findings include: Review of R46's annual "Minimum Data Set (MDS)" located in the electronic medical record (EMR) under the "MDS" tab, with an Assessment Reference Date (ARD) of [redacted] indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated R46 was NJ Exec Order 26.4b1. The assessment revealed the resident [redacted] and NJ Exec Order 26.4b1. The assessment indicated the resident received NJ Exec Order 26.4b1. Review of a document provided by the facility titled "Admission Record" indicated R46 was originally admitted to the facility on [redacted] and recently readmitted to the facility on [redacted] with a diagnosis of NJ Exec Order 26.4b1 [redacted]. Review of R46's "Progress Notes," located in the EMR under the "Prog [Progress] Note" tab and	F 692	1. Resident 46 was [redacted] and interventions are put in place to prevent NJ Exec Order 26.4b1. 2. All residents have the potential to be affected by the deficient practice. The Registered Dietitian (RD) performed an audit on residents with significant weight loss to ensure that weekly weights were done as ordered. No other resident was affected by the deficient practice. 3. The [redacted] was in-serviced by the Lead RD to ensure that an order is written for residents where weekly weights is recommended. RD will also ensure that weekly weights are done and interventions are put in place to prevent future weight loss or to maintain weight. ADON in-serviced all nursing staff to ensure that weights are obtained for residents on weekly weights as ordered by the Physicians. 4. The RD will monitor 5 residents on weekly weights weekly x 4 weeks and then 5 residents monthly for 3 months. Results of the audits will be reported to the QA committee monthly. The QAPI Committee will make recommendations based upon the results	

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F 692	Continued From page 19 dated [redacted], indicated the resident was recently readmitted back to the facility on [redacted] with a new diagnosis of [redacted] and [redacted] The NJ Exec Order 26.4b1 recommended the facility do [redacted]. Review of R46's "[redacted]" located in the EMR under "[redacted]/Vitals" tab, indicated on [redacted] the resident NJ Exec Order 26.4b1. On [redacted] the resident's NJ Exec Order 26.4b1. Next to this date there was a notation which revealed the resident had NJ Exec Order 26.4b1 following a hospitalization from his last [redacted] taken on [redacted]. There were no NJ Exec Order 26.4b1 in R46's chart after the NJ Exec Order 26.4b1. The next [redacted] documented was on [redacted] and the resident's [redacted] at this time was [redacted]. Observations were made on [redacted] at 12:57 PM and [redacted] at 12:51 PM, for R46's lunch meal. The resident was observed to be able to [redacted] with NJ Exec Order 26.4b1. During an interview on 01/08/24 at 1:53 PM, Licensed Practical Nurse (LPN) 1 stated the [redacted] typically places her recommendations in the hard chart and the recommendation would then be sent to the primary physician. During an interview on 01/08/24 at 2:19 PM, LPN6 stated the standard for a resident who was admitted or readmitted was to [redacted] them once a NJ Exec Order 26.4b1. During an interview on 01/09/24 at 2:06 PM, the [redacted] confirmed R46 was not [redacted] NJ Exec Order 26.4b1 [redacted] s per her recommendations. The [redacted] stated she typically would speak with the nurse	F 692	of the audits. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. 5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	

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F 692	Continued From page 20 and then write an order in the paper chart. The NJ Exec NJ Exec Order 26.4b1 confirmed that she did not write an order for for R46. During an interview on 01/10/24 at 9:57 PM, the U.S. FOIA (b) (6)) stated normally any recommendation would be written on a doctor order sheet and this would then be relayed to the primary physician and if approved by the doctor, the order would then be implemented. Review of a policy provided by the facility titled "Weight Management/Gain Program," dated 07/01/23 indicated ". . .The weight maintenance/gain program is designed to promote weight gain or maintenance in residents. . .Weights will be recorded weekly, unless otherwise recorded. . ." NJAC 8:39-17.1(c) NJAC 8:39-17.2(d) NJAC 8:39-27.2(e)	F 692		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		3/8/24

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F 761	Continued From page 21 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and facility policy review, the facility failed to ensure medications were stored in a locked storage area when left unattended for one of eight medication carts in the facility and failed to maintain medications in the original package delivered from pharmacy for two of eight medication carts. Findings include: During an observation on 01/08/24 at 1:56 PM to 2:01 PM, Licensed Practical Nurse (LPN)6 left the medication cart outside of Resident (R)96's room unlocked and unattended while LPN6 went into R96's room to give the resident medication. There were three residents seated in the hallway at the time of observation. LPN6 was unable to visualize the medication cart once inside of the resident's room. During an interview on 01/08/24 at 2:01 PM, LPN6 stated, " I couldn't see the cart when I went into the room. I should have checked my cart before I went into the room to give the	F 761	1. LPN6 was in-serviced by ADON regarding locking the medication cart when giving medications. No resident was affected by the deficient practice. RN1 was in-serviced by ADON that loose pills in the medication cart should be discarded. No resident was affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. All medication carts were checked for loose pills and expired medication. 3. The ADON initiated an in-service to all licensed nurses on: a. Storage of medications, including ensuring that medication cart is locked and not leaving it unattended. b. All expired medications must be discarded and reordered from the pharmacy as needed. c. Loose pills in the medication cart must be discarded.	

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	315112	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 22 medication." During an observation and interview on 01/10/24 at 9:34 AM, Registered Nurse (RN)1's medication cart on the seventh floor had pills that were noted to be loose in the second drawer and not in the original package from the pharmacy as follows: one round white pill with "40" imprinted on one side, one peach oval pill with "5" imprinted on it, one light green pill with "ARI [Aripiprazole]" imprinted on one side, one small white round pill, and one small white oval pill. In the third drawer of this medication cart, the following pills were also noted to be loose in the drawer and not in the original package from the pharmacy: one medium oval pill with "16" imprinted on one side and one small white oval pill. In the narcotic drawer the following pill was noted to be loose in the drawer without being in the original package from the pharmacy: one small, round pill with "R5" imprinted on one side. RN1 confirmed that the loose pills should have been discarded. During an observation and interview on 01/10/24 at 1:55 PM, the medication cart on the sixth floor had four boxes of Hydrocortisone Acetate Suppositories 30 mg (milligram) which had an expiration date of 12/23. LPN4 stated, "The nurses that checked this cabinet for expired medications should have pulled these boxes so they could not be used and reordered from pharmacy." During an interview on 01/10/24 at 3:15 PM, the [redacted] confirmed the medication cart should be locked when unattended by the nurse, the loose pills should have been discarded, and the expired medication should had been discarded and reordered from the pharmacy.	F 761	These education will be provided to newly-hired licensed nurses, and to all licensed nurses annually and as needed. 4. The DON/Designee will observe 3 nurses/week during Medication pass to ensure medication carts are locked and not left unattended x 2 weeks, then bi-weekly x 2 weeks then monthly x 3 months. The DON/Designee will also audit medication carts and medication storage areas weekly x 2 weeks, Bi-weekly x 2 weeks then monthly x 3 months. Results of the audits will be reported to the QA committee monthly. The QAPI Committee will make recommendations based upon the results of the audits. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. 5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	

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F 761	Continued From page 23 Review of facility policy "Medication Administration" dated 07/23 revealed, " ...Lock medication cart before entering resident/patient room. Never leave the medication cart open and unattended ..."	F 761		
F 880 SS=D	NJAC 8:39-29.4(h) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		3/8/24

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F 880	Continued From page 24 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 25 Based on observation, interview, record review, and facility policy review, the facility staff failed to place signage on a resident's door notifying all who enter this was resident was in [redacted] for one (Resident (R)13) of one resident reviewed for [redacted] out of a total sample of 55 residents. Findings include: Review of R13's undated "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed this resident was readmitted to the facility on [redacted] with the diagnosis of [redacted]. Review of R13's admission "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of [redacted] revealed a "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, which indicated R13 was NJ Exec Order 26.4b1 [redacted] During an observation and interview on 01/07/2023 at 10:07 AM, an [redacted] bin was observed outside of R13's room that contained personal protective equipment (PPE) to be used when entering the room of a resident that is on NJ Exec Order 26.4b1. There was no sign on the door alerting the type of [redacted] Licensed Practical Nurse (LPN)3 confirmed there should be signage R13's door. Review of R13's "Physician Orders," under the "Orders" tab in the EMR, revealed an order dated [redacted] which indicated, "NJ Exec Order 26.4b1." During an interview on 01/09/2024 at 2:17 PM,	F 880	1. A "NJ Exec Order 26.4b1" signage was place on Resident 13's door. 2. Residents on Transmission-Based Precautions (TBP) have the potential to be affected by the deficient practice. The Infection Control Preventionist (ICP) performed an audit on residents on TBP to ensure that they all have proper signage on the door. 3. The ICP initiated an in-service to all nursing staff regarding placing a signage on the door for residents on TBP. This education will be provided to newly-hired licensed nurses, and to all licensed nurses annually and as needed.4. The ICP will audit all residents on TBP for 3 months to ensure that proper signage is on the resident's door. Results of the audits will be reported to the QA committee monthly. The QAPI Committee will make recommendations based upon the results of the audits. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. 5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	

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F 880	Continued From page 26 the U.S. FOIA (b) (6) stated, "The unit manager or the nurse that receives the patient is responsible for getting the correct signage on the door." The U.S. confirmed there should be signage on R13's door. Review of the facility policy "Transmission Based Precautions" dated for 07/23 indicated, " ... Room entry signage indicating what type of Transmission-Based Precautions and appropriate PPE to be used ..."	F 880		
F 883 SS=E	NJAC 8:39-19.4(a) Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza	F 883		3/8/24

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F 883	Continued From page 27 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to offer one of five residents (Resident (R) 131) reviewed for NJ Exec Order 26.4b1 [redacted] and/or their representatives, the	F 883	1. Resident 131 was offered the NJ Exec Order 26 Facility's NJ Exec Order 26.4b1 policy was updated to ensure it reflected current CDC recommendations. 2. All residents have the potential to be affected by the deficient practice.	

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F 883	Continued From page 28 opportunity for the resident to be NJ Exec Order 26.4b1 in accordance with nationally recognized standards out of a total sample of 55 residents. The facility failed to offer R131 the opportunity to be NJ Exec Order 26.4b1 with NJ Exec Order 26.4b1 or one dose of NJ Exec Order 26.4b1 in accordance with nationally recognized standards. This practice had the potential to increase the risk for this resident to contract NJ Exec Order 26.4b1 In addition, the facility failed to ensure their NJ Exec Order 26.4b1 policies reflected current CDC recommendations. Findings include: Review of the CDC website titled "Pneumococcal Vaccination: Summary of Who and When to Vaccinate," effective 01/28/22, indicated ". . . CDC recommends pneumococcal vaccination for all adults 65 years or older . . . For adults 65 years or older who have not previously received any pneumococcal vaccine, CDC recommends you . . . Give 1 dose of PCV [Pneumococcal Conjugate Vaccine] 15 or PCV20 . . . If PCV15 is used, this should be followed by a dose of PPSV 23 at least one year later. The minimum interval is 8 weeks and can be considered in adults with an immunocompromising condition, cochlear implant, or cerebrospinal fluid leak . . . If PCV20 is used, a dose of PPSV23 is NOT indicated . . . For adults 65 years or older who have only received a PPSV23, CDC recommends you . . . May give 1 dose of PCV15 or PCV20 . . . The PCV15 or PCV20 dose should be administered at least one year after the most recent PPSV23 vaccination. Regardless of if PCV15 or PCV20 is given, an additional dose of PPSV23 is not recommended since they already received it. For adults 65 years or older who have only received	F 883	An audit was initiated for all residents to ensure that residents and/or their representatives are given the opportunity to receive the pneumonia vaccination in accordance with nationally recognized standards. 3. The ICP initiated an in-service to all nursing staff on current CDC Pneumococcal Vaccine recommendations. This education will be provided to newly-hired licensed nurses, and to all licensed nurses annually and as needed. 4. The ICP will audit 5 residents/weekly to ensure that resident and/or resident representative are given the opportunity to receive the pneumonia vaccination in accordance with nationally recognized standards x 4 weeks, and then 5 residents monthly for 3 months to ensure continued use is warranted. Results of the audits will be reported to the QA committee monthly. The QAPI Committee will make recommendations based upon the results of the audits. The QAPI Committee will recommend tapering and dissolution of audits once consistent compliance has been achieved. 5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	

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F 883	Continued From page 29	F 883		

PCV13, CDC recommends you . . . Give PPSV23 as previously recommended . . . For adults who have received PCV13 but have not completed their recommended pneumococcal vaccine series with PPSV23, one dose of PCV20 may be used if PPSV23 is not available. If PCV20 is used, their pneumococcal vaccinations are complete . . . "

Review of a document provided by the facility titled "Admission Record" indicated R131 was admitted to the facility on [redacted]. The resident was over the [redacted] upon admission to the facility.

Review of a document provided by the facility titled "Updated [redacted] dated [redacted], indicated R131 received [redacted]

During an interview on 01/08/24 at 9:56 AM, the [redacted] confirmed R131 was not offered any other [redacted] other than the [redacted]

During an interview on 01/09/24 at 9:49 AM, the [redacted] stated she was not aware of the updated CDC recommendations for the [redacted]

Review of a facility policy titled "Pneumococcal Vaccine (Series)," dated 07/23, indicated ". . .It is our policy to offer our residents, staff, and volunteer workers immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. . .Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall

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F 883	Continued From page 30 be documented, including efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received...No previous vaccination (or vaccination status is unknown): PCV13 first, then PPSV23 one year later. . ." NJAC 8:39-19.4(h)(i)	F 883		

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	060902	A. BUILDING: _____ B. WING _____	C 01/10/2024

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	1. 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) for the following weeks: a. 1/29/23 to 2/4/23 b. 2/12/23 to 2/18/23 c. 2/26/23 to 3/4/23 d. 4/9/23 to 4/15/23 e. 5/14/23 to 5/20/23 f. 6/25/23 to 7/01/23 g. 7/9/23 to 7/15/23 h. 12/26/23 to 1/6/24 2. All residents have the potential to be affected by the deficient practice of not meeting the NJ Staffing requirement	3/8/24

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

Electronically Signed | 02/01/24

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S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 01/29/2023 to 02/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -01/29/23 had 22 CNAs for 263 residents on the day shift, required at least 33 CNAs. -01/30/23 had 23 CNAs for 263 residents on the day shift, required at least 33 CNAs. -01/31/23 had 23 CNAs for 263 residents on the day shift, required at least 33 CNAs. -02/01/23 had 22 CNAs for 263 residents on the day shift, required at least 33 CNAs. -02/02/23 had 22 CNAs for 263 residents on the day shift, required at least 33 CNAs. -02/03/23 had 25 CNAs for 260 residents on the day shift, required at least 32 CNAs. -02/04/23 had 22 CNAs for 260 residents on the day shift, required at least 32 CNAs. 2. For the week of Complaint staffing from 02/12/203 to 02/18/2023, the facility was deficient	S 560	ratios. 3. The following measures have been put into place to prevent the deficient practice from recurring: a. 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. b. Incentives are offered to CNAs to work extra shifts such as gift cards and raffles. c. Administrator has reached out to CNA schools to advise we are hiring and willing to train new graduates. 4. The Administrator/Designee will review the staffing schedule weekly to monitor the staffing ratio on the day shift for 3 months. a) All results of the monitoring will be presented to the QA committee for review and any additional monitoring or modification of this plan monthly for 3 months. b) The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. 5. The Date of Completion is March 8, 2024. The administrator is responsible for the implementation of the Plan of Correction.	

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	060902	A. BUILDING: _____ B. WING _____	C 01/10/2024

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HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 in CNA staffing for residents on 7 of 7 day shifts as follows: -01/12/23 had 23 CNAs for 265 residents on the day shift, required at least 33 CNAs. -01/13/23 had 23 CNAs for 265 residents on the day shift, required at least 33 CNAs. -01/14/23 had 22 CNAs for 265 residents on the day shift, required at least 33 CNAs. -01/15/23 had 22 CNAs for 265 residents on the day shift, required at least 33 CNAs. -01/16/23 had 25 CNAs for 270 residents on the day shift, required at least 34 CNAs. -01/17/23 had 25 CNAs for 270 residents on the day shift, required at least 34 CNAs. -01/18/23 had 22 CNAs for 270 residents on the day shift, required at least 34 CNAs. 3. For the week of Complaint staffing from 02/26/2023 to 03/04/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -02/26/23 had 21 CNAs for 269 residents on the day shift, required at least 34 CNAs. -02/27/23 had 25 CNAs for 269 residents on the day shift, required at least 34 CNAs. -02/28/23 had 23 CNAs for 268 residents on the day shift, required at least 33 CNAs. -03/01/23 had 25 CNAs for 267 residents on the day shift, required at least 33 CNAs. -03/02/23 had 23 CNAs for 267 residents on the day shift, required at least 33 CNAs. -03/03/23 had 22 CNAs for 267 residents on the day shift, required at least 33 CNAs. -03/04/23 had 24 CNAs for 267 residents on the day shift, required at least 33 CNAs. 4. For the week of Complaint staffing from04/09/2023 to 04/15/2023, the facility was	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060902	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 3 deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -04/09/23 had 22 CNAs for 266 residents on the day shift, required at least 33 CNAs. -04/10/23 had 24 CNAs for 266 residents on the day shift, required at least 33 CNAs. -04/11/23 had 26 CNAs for 265 residents on the day shift, required at least 33 CNAs. -04/12/23 had 25 CNAs for 265 residents on the day shift, required at least 33 CNAs. -04/13/23 had 26 CNAs for 265 residents on the day shift, required at least 33 CNAs. -04/14/23 had 25 CNAs for 265 residents on the day shift, required at least 33 CNAs. -04/15/23 had 23 CNAs for 264 residents on the day shift, required at least 33 CNAs. 5. For the week of Complaint staffing from 05/14/2023 to 05/20/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -05/14/23 had 23 CNAs for 265 residents on the day shift, required at least 33 CNAs. -05/15/23 had 22 CNAs for 265 residents on the day shift, required at least 33 CNAs. -05/16/23 had 25 CNAs for 265 residents on the day shift, required at least 33 CNAs. -05/17/23 had 25 CNAs for 265 residents on the day shift, required at least 33 CNAs. -05/18/23 had 28 CNAs for 270 residents on the day shift, required at least 34 CNAs. -05/19/23 had 22 CNAs for 270 residents on the day shift, required at least 34 CNAs. -05/20/23 had 22 CNAs for 267 residents on the day shift, required at least 33 CNAs. 6. For the week of Complaint staffing from 06/25/2023 to 07/01/2023, the facility was	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060902	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 4 deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -06/25/23 had 21 CNAs for 266 residents on the day shift, required at least 33 CNAs. -06/26/23 had 23 CNAs for 266 residents on the day shift, required at least 33 CNAs. -06/27/23 had 27 CNAs for 266 residents on the day shift, required at least 33 CNAs. -06/28/23 had 28 CNAs for 266 residents on the day shift, required at least 33 CNAs. -06/29/23 had 27 CNAs for 268 residents on the day shift, required at least 33 CNAs. -06/30/23 had 23 CNAs for 268 residents on the day shift, required at least 33 CNAs. -07/01/23 had 24 CNAs for 268 residents on the day shift, required at least 33 CNAs. 7. For the week of Complaint staffing from 07/09/2023 to 07/15/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -07/09/23 had 23 CNAs for 273 residents on the day shift, required at least 34 CNAs. -07/10/23 had 26 CNAs for 272 residents on the day shift, required at least 34 CNAs. -07/11/23 had 23 CNAs for 271 residents on the day shift, required at least 34 CNAs. -07/12/23 had 26 CNAs for 271 residents on the day shift, required at least 34 CNAs. -07/13/23 had 26 CNAs for 271 residents on the day shift, required at least 34 CNAs. -07/14/23 had 26 CNAs for 271 residents on the day shift, required at least 34 CNAs. -07/15/23 had 23 CNAs for 271 residents on the day shift, required at least 34 CNAs. 8. For the 2 weeks of staffing prior to survey from 12/24/2023 to 01/06/2024, the facility was	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060902	A. BUILDING: _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 5 deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -12/24/23 had 23 CNAs for 263 residents on the day shift, required at least 33 CNAs. -12/25/23 had 22 CNAs for 259 residents on the day shift, required at least 32 CNAs. -12/26/23 had 21 CNAs for 257 residents on the day shift, required at least 32 CNAs. -12/27/23 had 23 CNAs for 256 residents on the day shift, required at least 32 CNAs. -12/28/23 had 24 CNAs for 256 residents on the day shift, required at least 32 CNAs. -12/29/23 had 21 CNAs for 256 residents on the day shift, required at least 32 CNAs. -12/30/23 had 23 CNAs for 256 residents on the day shift, required at least 32 CNAs. -12/31/23 had 22 CNAs for 257 residents on the day shift, required at least 32 CNAs. -01/01/24 had 24 CNAs for 257 residents on the day shift, required at least 32 CNAs. -01/02/24 had 24 CNAs for 257 residents on the day shift, required at least 32 CNAs. -01/03/24 had 28 CNAs for 257 residents on the day shift, required at least 32 CNAs. -01/04/24 had 26 CNAs for 257 residents on the day shift, required at least 32 CNAs. -01/05/24 had 25 CNAs for 256 residents on the day shift, required at least 32 CNAs. -01/06/24 had 24 CNAs for 254 residents on the day shift, required at least 32 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315112	A. Building B. Wing	3/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0604 Reg. # 483.10(e)(1), 483.12(a)(2) LSC	Correction Completed 03/08/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315112 Y1	A. Building B. Wing Y2	3/14/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0604	Correction	ID Prefix F0609	Correction	ID Prefix F0610	Correction
Reg. # 483.10(e)(1), 483.12(a)(2)	Completed	Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4)	Completed	Reg. # 483.12(c)(2)-(4)	Completed
LSC	03/08/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix F0637	Correction	ID Prefix F0644	Correction	ID Prefix F0692	Correction
Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.25(g)(1)-(3)	Completed
LSC	03/08/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix F0761	Correction	ID Prefix F0880	Correction	ID Prefix F0883	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.80(d)(1)(2)	Completed
LSC	03/08/2024	LSC	03/08/2024	LSC	03/08/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/10/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER Y1	MULTIPLE CONSTRUCTION Y2	DATE OF REVISIT Y3
060902	A. Building B. Wing	3/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/08/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060902		3/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/08/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 1/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315112	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	**9020 WALL STREET** **NORTH BERGEN, NJ 07047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 01/10/2024. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/10/24 and was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Hudsonview 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 generator does approximately 50 % of the building per the Maintenance Director. The current occupied beds are 252 of 271.	K 000		
K 293 SS=F	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies	K 293		3/8/24

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

Electronically Signed | 02/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315112	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	**9020 WALL STREET** **NORTH BERGEN, NJ 07047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 1 with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure directional signs, which showed the direction of travel, were placed in every location where the direction of travel to reach the nearest exit was not apparent in accordance with NFPA 101 (2012 edition) section 7.10.2.1. This deficient practice had the potential to affect all 252 residents who resided at the facility. Findings include: An observation on 01/10/24 between 11:00 AM and 1:30 PM revealed directional signs were not placed to indicate the direction of travel from the rehabilitation on the 10th floor to the exterior exit stair off the roof. During an interview at the time of the observation, the U.S. FOIA (b) (6) confirmed that the stairs off the roof did not have an illuminated exit sign. NJAC 8:39-31.1(c), 31.2(e)	K 293	1. Directional signs will be placed by the facilities vendor to indicate the direction of travel from the rehabilitation gym on the 10th floor to the exterior exit stairs off the roof. 2. All residents have the potential to be affected by this deficient practice. The facilities vendor will be installing the appropriate illuminated exit signs. The approximate completion date for this project will be March 8th 2024. 3. The Director of Maintenance will conduct weekly audits for four weeks and then monthly thereafter for three months to ensure that all directional signs are in place and that the signs are in good working order. The QA committee will meet quarterly, and all findings will be brought to the QA committee. The Administrator is responsible for the implementation of this plan of correction.	
K 311 SS=F	Vertical Openings - Enclosure CFR(s): NFPA 101 Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6	K 311		3/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315112	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	**9020 WALL STREET** **NORTH BERGEN, NJ 07047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 311	Continued From page 2 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure fire rated door assemblies for stairway exit doors were equipped with fire exit hardware in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 19.3.1. This deficient practice had the potential to affect all 252 residents who resided at the facility. Findings include: Observations on 01/10/24 between 11:00 AM and 1:30 PM revealed six of 20 stairway doors, located in the south stairway on the second, fifth, sixth, seventh and eighth floors were equipped with panic hardware which violated the listing of the rated fire door assembly. During an interview at the time of observation, the U.S. FOIA (b) (6) confirmed the stairway doors were equipped with panic hardware. NJAC 8:39-31.2(e) NFPA 80	K 311	1. The 6 doors located in the south stairway on the second, fifth, sixth, seventh and eighth floors which were equipped with panic hardware that violated the listing of the rated door assembly will be replaced with the appropriate hardware that conforms to the NFPA Safety Code. 2. All residents have the potential to be affected by this deficient practice. The Maintenance Director will replace all panic hardware from the doors located in the south stairway on the 2nd 5th 6th 7th and 8th floors that violated the listing of the rated fire door assembly with appropriate panic hardware. The completion date for this project will be March 8th 2024. 3. The Maintenance Director will conduct a facility wide inspection on all doors to confirm that they are equipped with correct panic hardware. 4. The Director of Maintenance will conduct weekly audits for four weeks and then monthly thereafter for three months to ensure that all doors have fire rated door assemblies that are equipped with appropriate fire exit hardware and in good working condition. The QA committee will meet quarterly, and all findings will be brought to the QA committee. The administrator is responsible for the implementation of this plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315112	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	**9020 WALL STREET** **NORTH BERGEN, NJ 07047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 3	K 761		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the fire doors were annually inspected in accordance with NFPA 101 Life Safety Code (2012 edition) 7.2.1.15. This deficient practice had the potential to affect all 252 residents who resided at the facility. Findings include: A review of the facility's fire door inspection binder dated for 2023, provided by the U.S. FOIA (b) (6) [redacted], revealed fire door inspections were conducted at the facility; however, the fire doors were not being inspected in accordance with the Code. Observations on 01/10/24 between 11:00 AM and 1:30 PM revealed no indication the fire door	K 761	1. The facility will ensure that the fire doors are annually inspected in accordance with the life safety code. 2. All residents could be affected by this deficient practice. The Maintenance Director will be performing the appropriate education and training that acquires the knowledge and demonstrates the ability to do an accurate annual test of all fire door assemblies annually. 3. The Maintenance Director will conduct an annual inspection and testing of all fire door assemblies. Nonrated doors including corridor doors to patient rooms and smoke barrier doors will be part of this inspection as part of the facility maintenance program. 4. The Director of Maintenance will conduct weekly audits for four weeks and	3/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315112	A. BUILDING **01** B. WING _____	**01/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	**9020 WALL STREET** **NORTH BERGEN, NJ 07047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 4 assemblies that were equipped with panic hardware failed the inspection. During an interview at the time of observation, the U.S. FOIA (b) (6) confirmed fire doors were not inspected correctly. NJAC 8:39-31.1(c), 31.2(e) NFPA 80	K 761	then monthly thereafter for three months to ensure that all fire door assemblies are in good working condition and meet all the requirements of the life safety code. The QA committee will meet quarterly, and all findings will be brought to the QA committee. The administrator is responsible for the implementation of this plan of correction.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315112	A. Building 01 - MAIN BUILDING 01 B. Wing	3/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HUDSONVIEW HEALTH CARE CENTER	9020 WALL STREET NORTH BERGEN, NJ 07047

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0293	Correction Completed 03/08/2024	ID Prefix Reg. # NFPA 101 LSC K0311	Correction Completed 03/08/2024	ID Prefix Reg. # NFPA 101 LSC K0761	Correction Completed 03/08/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
1/10/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO