STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315307	A. BUILDING _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	**7600 RIVER RD 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 This facility is in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS Complaint #'s: NJ00157696, NJ00156541, NJ00156374, NJ00154588, NJ00154495 Survey Date: 4/26/23 Census: 156 Sample: 31 + 3 (Closed Record) + 5 (Extended Survey) A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can	F 584		6/16/23

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

Electronically Signed | 05/19/2023

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

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F 584	Continued From page 1 receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide a homelike environment during meal service as evidenced by the following. The deficient practice was observed on 2 out of 3 facility floors during lunch service observation. This deficient practice was evidenced by the following:	F 584	1. Staff serving and assisting residents with their meals were educated to remove the residents meals from the meal tray and to remove any empty containers, straw paper or other trash from in front of the residents while residents were eating their meals, to ensure a homelike environment for the residents during mealtimes.	

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F 584	Continued From page 2 1. On 4/10/23 at 1:00 PM, during the lunch meal service located on the [redacted] Floor dining room (DR), the surveyor observed that all meals in the DR were served and remained on meals trays. The surveyor also observed the Certified Nursing Assistants (CNA's) who were providing assistance with set-up to the residents in the DR left the lid from the food plate on the table and placed all the empty milk and juice containers along with straw papers and other trash in front of the resident. The garbage along with the meal tray was left on the table in front of the resident through the entirety of the meal, while residents were eating. On 4/11/23 at 12:55 PM, during the lunch meal service on the [redacted] Floor DR, the surveyor observed that all meals in the DR were once again served and remained on meals trays. The surveyor also observed the Certified Nursing Assistants (CNAs) who were providing assistance with set-up to the resident in the DR left the lid from the food plate on the table and placed all the empty milk and juice container along with straw papers and other trash in front of the resident. The meal was left on the meal tray as well as the garbage in front of the resident through the entirety of the meal, while residents were eating. On 4/12/23 at 8:50 AM, during the breakfast meal service located on the [redacted] Floor DR, the surveyor observed that all meals in the DR were served and remained on meals trays throughout the meal. The surveyor also observed this on the [redacted] floor dayroom area, where the breakfast trays remained under the meal served while the resident was eating. On 4/20/23 at 10:52 AM, the surveyor interviewed	F 584	2. All residents have the potential to be affected by the same deficient practice. 3. Staff serving and assisting residents with their meals were educated on the policy and procedure related to quality of life and dignity and living in a homelike environment. 4. The ADON and / or Designee will audit 1 breakfast, 2 lunch and 2 dinner meal services weekly x 3 months. Any discrepancies will be immediately addressed. Audits will be reviewed through the monthly QAPI process for the next three months.	

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F 584	Continued From page 3	F 584		

the [redacted] floor [redacted], who stated, it's the facilities' normal practice to leave the trays on the tables with the plates, cups and utensils for the resident in the dining as well as for residents who eat in their rooms. The [redacted] did agree that leaving the meals on the trays does not create a homelike environment.

On 4/20/23 at 1:54 PM, the surveyor team met with the [redacted] to review our concerns. The [redacted] stated they would provide response tomorrow.

On 4/21/23 at 12:47 PM, the surveyor team met with the [redacted] and [redacted] for their responses. The [redacted] agreed that all items should be removed off trays for resident in the dining room to create a homelike environment.

2. On 4/18/23 at 12:15 PM, during lunch meal service on the [redacted] floor dining room, the surveyor observed that all the meals in the DR were served on meal trays and were left on the trays in front of the residents.

On 4/18/23 at 12:24 PM, the surveyor interviewed the [redacted] floor [redacted] She stated that the CNAs and Nurses will assist the residents to "open everything for them" and that if the residents require assistance with feeding, they will be assisted. She further stated that the residents' meals are served on the trays during the duration of the meals. The [redacted] agreed that leaving the meals in the trays does not create a homelike environment for the residents during mealtimes.

On 4/21/23 at 1:28 PM, the team met with the

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F 584	Continued From page 4 US FOIA (b)(6) and US FOIA (b)(6) The surveyor verbalized the above concern. The US FOIA (b)(6) stated, "The items on the trays should be removed during mealtimes."	F 584		
F 655 SS=D	N.J.A.C. 8:39-4.1(a)12 Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		6/16/23

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F 655	Continued From page 5 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a person-centered baseline care plan (CP) for a resident within 48 hours of admission. This deficient practice was identified for 1 of 2 residents reviewed, (Resident #381) who had Ex Order 26.4B1 [redacted] This deficient practice was evidenced as follows: On 4/10/23 at 12:43 PM, during the initial tour, the surveyor observed Resident #381 sitting in a wheelchair in their room. The surveyor greeted the resident who responded in Ex Order 26.4B1 On 4/17/23 at 12:20 PM, the surveyor observed Resident #381 sitting in their wheelchair in their room. The surveyor greeted the resident who responded in Ex Order 26.4B1 At around the same date and time, the surveyor interviewed the US FOIA (b)(6) [redacted] assigned to the resident. The US FOIA (b) stated that Resident #381 speaks and understands only	F 655	1. Resident #381 was provided with a NJ Exec Order 26.4b1 in the room. Baseline Care Plan of Resident #381 was completed by the IDT Team. 2. All residents have the potential to be affected by the same deficient practice. 3. Nursing staff and Interdisciplinary team were reeducated on policy and procedure for completion of Baseline Care Plan and to ensure that a communication board tool is provided to residents that do not speak the primary language of the facility. 4. The DON / designee will audit 5 residents charts for Baseline Care Plan weekly to ensure that the policy and procedure are being followed and communication board is provided to resident that do not speak the primary language of the facility for x 3 months. Any identified issues will be immediately addressed. Audits will be reviewed through the	

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F 655	Continued From page 6 Ex Order 26.4B1 and that a Ex Order 26.4B1 and a NJ Exec Order 26.4b1 would be needed. The surveyor brought the US FOIA (b) to Resident #381's room. The US FOIA (b) acknowledged that there was no NJ Exec Order 26.4b1 tool located in the resident's room and that the resident "never had one." A review of Resident #381's medical record revealed the following: A Face Sheet (an admission record) revealed that Resident #381 was admitted to the facility with diagnoses that included but not limited to Ex Order 26.4B1 The Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date of Ex Order 26.4B, revealed a Brief Interview Status score of Ex O out of 15, indicating that the resident had Ex Order 26.4B1 . The MDS assessment further reflected under "Section A1100, Language" that Resident #381 Ex Order 26.4B1 " was his/her NJ Exec Order 26.4b1 . A review of Resident #381's CP did not identify that the resident was Ex Order 26.4B1 and required a NJ Exec Order 26.4b1 and an NJ Exec Order 26.4b1 . On 4/17/23 at 12:52 PM, the surveyor interviewed the US FOIA (b)(6) . She stated	F 655	monthly QAPI process for the next three months.	

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F 655	Continued From page 7 that Resident #381 speaks and understands only [Ex Order 26.4B1] and that a [Ex Order 26.4B1] and a NJ Exec Order 26.4b1 would be needed. The [US FOIA (b)(6)] acknowledged that the resident did not have a baseline CP implemented to address the NJ Exec Order 26.4b1. She further stated that a baseline CP should have been initiated for the resident because "it should be important to relay their needs." The [US FOIA (b)(6)] was not able to locate or demonstrate a NJ Exec Order 26.4b1 in the resident's room. A review of the facility policy titled, "Care Plans-Baseline" with a reviewed date of 2/2023, revealed the following under Policy Statement, "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty eight (48) hours of admission. A further review of the policy indicated under Policy Interpretation and Implementation, "1. To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission. 3. The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan. On 4/21/23 at 1:08 PM, the team met with the US FOIA (b)(6) and US FOIA (b)(6). The surveyor verbalized the above concern. The [US FOIA (b)] acknowledged that Resident #381 did not have a baseline CP implemented to address [NJ Exec Order 26.4b] which should have been implemented. NJAC 8:39-27.1(a)	F 655		

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F 658	Continued From page 8	F 658		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain professional standards of nursing practice for 3 of 31 sampled residents observed, Resident #92, #228 and #114 . This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 4/18/23 at 8:45 AM, during the medication administration observation (med pass), the Surveyor observed the [redacted] Floor US FOIA (b)(6) [redacted] preparing Ex Order 26.4B1 medications for administration to a Ex Order 26.4B1) resident, Resident #92. The [redacted] opened a packet prepared by the pharmacy, marked for 9:00 AM	F 658	1. The identified US FOIA (b)(6) was educated on the process of medication administration and proper procedure of documentation. The PN that received the [redacted] order was reeducated to ensure that the order received from the physician was entered into the electronic medical record and to notify the [redacted] company. NJ Exec Order 26.4b1 Nurse that provided the treatment of Resident #114 and [redacted] that signed the treatment not performed were reeducated on the Charting and Documentation Policy. 2. All residents and patients are at risk for the same deficient practice. 3. Licensed Nursing staff were reeducated on: 1. Policy and Procedure for medication administration and and proper documentation. 2. Ensure that a telephone order received from the physician must be documented in the electronic medical record. Notify and document the Xray company of the order received.	6/16/23

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F 658	Continued From page 9 administration. The Surveyor noted that the US FOIA (b) computer was on the screen saver mode. No electronic medication administration record (eMAR) was checked prior to preparing the medication removed from the packet. The US FOIA then opened the eMAR to check for other medications that were due to be administered to Resident #92. The US FOIA noted that there were two NJ Ex Order 26.4b1 medications ordered for Resident #92 that the US FOIA removed from the control lock box located in the medication cart. The US FOIA removed [redacted] tablet of Ex Order 26.4B1 [redacted] The US FOIA crushed the medications for administration to Resident #92 and completed the administration process. Once the US FOIA had completed her med pass for Resident #92, the surveyor interviewed her. The US FOIA explained that she should have verified the medications in the packet with the physician orders documented on the eMAR before removing the medication from the packet containing numerous medications prepared by the pharmacy. The Surveyor also asked the US FOIA if she had documented the removal of the NJ Exec Order 26.4b medications from the NJ Exec Order 26.4b1 Administration Record. The US FOIA opened the sheets designated for the Ex Order 26.4B1 [redacted], which were dated, signed but lacked any documentation of time that the sheets were signed. The US FOIA	F 658	3. Policy on Charting and Documentation when providing wound treatments to residents. 4. The Unit Managers / Designee will audit 5 residents weekly x 3 months to ensure compliance. Any issues will be addressed immediately. Result of audit will be reviewed monthly during the QAPI process.	

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F 658	Continued From page 10 revealed that she had documented the removal of both medications on the declining sheets prior to removing the medication and prior to starting Resident #92's med pass. The [US FOIA] indicated that this is not the appropriate process for documenting on the [ND Ex Order 26.4] [redacted] declining sheet. The [US FOIA] clarified that she should check the amounts listed on the declining sheet prior to removing the medication from storage, see that the amounts match and only document after removing the medication, including the time the medication was removed from storage. A review of Resident #92's medical record revealed the following: Review of Resident #92's Admission Record (AR) indicated that the resident was admitted with diagnoses that included but were not limited to [Ex Order 26.4B1] [redacted] A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated [Ex Order 26.4B1] identified that Resident #92 should not have a Brief Interview for Mental Status (BIMS) evaluation as the resident's [Ex Order 26.4B1] [Ex Order 26.4B1] 2. On 4/18/23 at 10:06 AM, during the med pass, the Surveyor observed the [Ex Orde] floor [US FOIA (b)(6)] [redacted] preparing whole medication for administration to Resident #228. The [US FOIA (b)] opened a packet containing numerous medications prepared by the pharmacy, marked	F 658		

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F 658	Continued From page 11 for 9:00 AM administration. The Surveyor noted that the US FOIA (b)(6) computer was on the screen saver mode. No eMAR was checked prior to preparing the medication removed from the packet. The US FOIA (b) then opened the eMAR to check for other medications that were due to be administered to Resident #228. The US FOIA (b) prepared numerous other medications placed in a medication cup. The US FOIA (b) poured water in a cup and proceeded to enter Resident #228's room. Resident #228 was seated in a wheelchair with a family member seated next to the resident. The family member advised the US FOIA (b) that Resident #228 received Ex Order 26.4B1 medication and Ex Order 26.4B1 Ex Order 26.4B The US FOIA (b) and Surveyor exited the room. The US FOIA (b) proceeded to check the Physician's order for Resident #228 in the presence of the Surveyor. The Physician's order dated Ex Order 26.4B1 stated, "Medications that can be Ex Order 26.4B1 per the manufacturer may be Ex Order 26.4B1 and administered together." Another Physician's order dated Ex Order 26.4B1 stated, Ex Order 26.4B1 ." The US FOIA (b) proceeded to Ex Order 26.4B the medication and pour Ex Order 26.4B1 water for administration to Resident #228. After completing the med pass for Resident #228, the Surveyor interviewed the US FOIA (b) The US FOIA (b) stated that she was not familiar with this resident. The US FOIA (b) acknowledged that she should have verified the Physician's orders carefully to familiarize herself with Resident #228's orders. A review of Resident #228's medical record	F 658		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 12 revealed the following: Review of Resident #228's Face Sheet AR indicated that the resident was admitted with diagnoses that included but were not limited to [redacted]. Review of Resident #228's Admission MDS dated [redacted], identified that Resident #228 had a BIMS of [redacted], indicating that the resident was [redacted]. Review of Resident #228's Care Plan (CP) describes that the resident, "has [redacted] In addition the CP documented that the resident, '[redacted] Review of the [redacted] Evaluation and Plan of Treatment dated [redacted] documents the recommendation for [redacted] and [redacted] An interview with the [redacted] on 4/24/23 at 1:33 PM verified that only [redacted] of food [redacted] and liquid [redacted]) was evaluated. The [redacted] added that there was never a request to evaluate for [redacted]. The Physician ordered to [redacted] the medication. Review of the Administering Medications Policy, under the Policy Interpretation and Implementation indicated: 5. The individual administering the medication must check the label against the	F 658		

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F 658	Continued From page 13 Physician's order to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. On 4/18/23 at 1:47 PM , the surveyor met with the US FOIA (b)(6) to discuss the results of the observation of morning med pass. The US FOIA (b) acknowledged that all medications should be verified with the Physician's orders prior to administration. The US FOIA (b) added that diet restrictions are posted within the eMAR and should be verified and followed. Complaint # NJ00156374 4. On 4/17/23 at 12:26 PM, the surveyor reviewed the closed medical record for Resident #478. A review of Resident #478's AR revealed that the resident was admitted to the facility with diagnoses that included but were not limited to; Ex Order 26.4B1 A review of the Progress Notes (PN) included the following note written by nursing staff, Ex Order 26.4B1 3:34 PM: during rounds, resident noted with NJ Exec Ord Ex Order 26.4B1 Dr. ... made aware	F 658		

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F 658	Continued From page 14 and order to transfer to ... ER (Emergency Room). supervisor was informed, family and ER made aware. resident was transferred for [redacted] Further review of the PN included the following note written by nursing staff, [redacted] 10:46 PM: [redacted] requested that resident be checked for Ex Order 26.4B1. Placed a call to PMD (primary medical doctor) and new order for [redacted])received." Another nursing PN reviewed, Ex Order 26.4B1 [redacted] (Activities of Daily Living). kept clean, [redacted] and [redacted] family visited and very supportive, at the time resident was [redacted] ." An additional review of the PN included the following note written by nursing staff, Ex Order 26.4B1 : admitted to [redacted])." Resident #478 did not return to the facility noted by the Universal Transfer Form dated [redacted] that revealed Resident #478 was transferred to the ER for [redacted] A review of the [redacted] Physician Order Report (POR) revealed that there was no order for a [redacted]	F 658		

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F 658	Continued From page 15 There was no documented evidence of an order for a Ex Order 26.4B1 was performed during the timeframe of NJ Exec Order 26.4 at 10:46 PM when the request for a Ex Order 26.4 was made until Ex Order 26.4B1 PM, when Resident #478 was transferred to the ER. On 4/19/23 at 11:13 AM, the surveyor interviewed the Ex Orde floor US FOIA (b)(6) regarding Resident #478 and the process of obtaining a Ex Order 26.4B The Ex Orde floor US FOIA (b)(6) confirmed that she could not find a Ex Order 26 ordered in the electronic medical record for Resident #478 from Ex Order 26.4B1 She revealed that she was not familiar with Resident #478. The Ex Order floor US FOIA (b)(6) stated that if a family member would have requested a Ex Order 26.4 the nurse would call the physician, get an order and then enter the order in the computer system. The US FOIA (b)(6) then stated that if the Ex Order 26.4 was ordered NJ Exec Order 26.4b1 then the Ex Order 26.4 would be performed the same day and if it was not ordered stat then the Ex Order 26 would be performed the following day. On 4/19/23 at 12:52 PM, the surveyor interviewed the US FOIA (b) regarding Resident #478 and the process for obtaining a Ex Order 26. The US FOIA (b) stated that the current electronic medical record system for documentation that the facility was using had been in use for the last four to five years and that the order for a Ex Order 26.4 could be in the progress notes. She added that the facility in the past had also used the hospitals electronic system and that the Ex Order 26 order could be in the hospitals electronic system. The surveyor then requested documented evidence that a Ex Order 26 was ordered by	F 658		

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the facility on or after [redacted].

On 4/20/23 at 10:07 AM, in the presence of the [redacted] and [redacted], the surveyor interviewed the [redacted] regarding Resident #478. The [redacted] could not provide the surveyor a [redacted] order or [redacted] result that was previously requested. The [redacted] revealed that a [redacted] was not ordered or done and that the Physician had seen the resident on [redacted], documenting that the resident was [redacted].

The [redacted] added that the family requested the [redacted] later that day. The [redacted] stated that the [redacted] was planned for [redacted]. The [redacted] explained that the resident [redacted] when the physician examined the resident and the [redacted] NJ Exec Order 26.4b1. The [redacted] was not sure of the reason the family requested the [redacted].

The [redacted] explained the process for obtaining a [redacted] included getting a Physician's order, then calling the [redacted] department in the hospital for an appointment. The [redacted] did not present any evidence of a Physician's order or an appointment with the hospital [redacted] department.

On 4/20/23 at 10:36 AM, in the presence of the hospital's [redacted], the surveyor interviewed the hospital's [redacted] regarding the process of obtaining a [redacted]. The [redacted] stated that the hospital would have to have a physician's order to perform a [redacted] on a resident from the nursing home facility since the resident would be considered an [redacted].

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The surveyor asked the [US FOIA] if there was an order for a [Ex Order 26] for Resident #478. The [US FOIA] reviewed the hospital's electronic medical record computer system and revealed that there was no order received for a [Ex Order 26] from Ex Order 26.4B1 prior to the ER admission. The [US FOIA] confirmed that the only [Ex Order 26] performed was done in the ER at 20:38 on [NJ Exec Order 26.4].

The surveyor reviewed the process with the [US FOIA] who explained that it was the responsibility of the nursing home to obtain a [Ex Order 26.4] for the nursing home through the hospital. The [US FOIA] explained that the hospital would have to receive a physician's order for the [Ex Order 26.4] via fax from the facility. The [US FOIA] added that the hospital would then be responsible to scan the order into the hospital's computer system. He verified that the hospital would not perform an [NJ Exec Order] without a physician's order or without the order being in the computer system.

A review of the document titled "image.png" provided by the [US FOIA (b)] revealed that there were no orders for a [Ex Order 26] from [NJ Exec Order 26.4] until the ER encounter on [NJ Exec Order 26.4].

On 4/20/23 at 12:24 PM, the surveyor interviewed the [US FOIA (b)] and [US FOIA (b)] regarding the [Ex Order 26.4] report that was provided to the survey team that day at 10:29 AM. The [US FOIA (b)] confirmed that the [Ex Order 26] report provided was done after the resident was transferred to the ER. The [US FOIA (b)] then verified that they could not find an order for the [Ex Order 26] requested.

On 4/20/23 at 1:52 PM, in the presence of the US FOIA (b)(6) from another facility, the surveyor team discussed the

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concern regarding the lack of a Physician's order and request for a [Ex Order 26.4] ordered or performed for Resident #478 in a timely manner.

A review of the facility provided policy titled "Request for Diagnostic Services" with a facility review date of 2/2023 included the following:
1. All requests for diagnostic services must be ordered by the resident's Attending Physician.
2. All orders for diagnostic services must be entered into the resident's medical record and signed by the Attending Physician.
3. Orders for diagnostic services will be carried out as instructed by the physician's order.
4. Emergency requests must be labeled "stat" to assure that prompt action is taken.

On 4/21/23 at 12:53 PM, in the presence of the survey team, the [US FOIA (b)] stated that she could not find any documenting orders, change of condition or an order for a [Ex Order 26.4]. The [US FOIA (b)] confirmed that there should have been an order for a [Ex Order 26.4] No further information was provided.
On 4/19/2023 at 11:10 AM, the surveyor observed [Ex Order 26.4B1] care on Resident #114 performed by the facility [NJ Exec Order 26.4b1] US FOIA (b)(6)).

A review of Resident #114's medical record revealed the following:

A review of Resident #114 AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1

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Ex Order 26.4B1 [redacted]

A review of the Quarterly MDS dated, NJ Exec Order 26.4b [redacted], revealed a BIMS score NJ Exe [redacted] of 15. This score suggests that Resident #114 has an Ex Order 26.4b [redacted] Ex Order 26.4B1 NJ [redacted].

A review of the electronic Medication Administration Record (eMAR), dated NJ Exec Order 26.4b1 [redacted], revealed a Physician's Order (PO) dated Ex Order 26.4B1 [redacted] (make sure to NJ Exec Or [redacted]."

A review of the Care Plan dated Ex Order 26.4B1 [redacted] for Ex Order 26.4B1 [redacted] revealed an intervention of weekly consult with Ex Order 26.4b1 NJ Exec Order 26.4b1 [redacted]

A review of the Progress Notes dated Ex Order 26.4B1 [redacted] through and including Ex Order 26.4B1 [redacted] revealed the lack of any documentation from the nurse observed (by the surveyor) performing Ex Order 26.4B1 [redacted] care on the NJ Exec Order 26.4b1 [redacted] day shift.

A review of the Treatment Administration History NJ Exec Order 26.4b1 [redacted] through NJ Exec Order 26.4b1 [redacted] revealed that the documentation on the eMAR for NJ Exec Order 26 [redacted] care performed on NJ Exec Order 26.4b1 [redacted] day shift was not the initials of the Ex Order 26.4B1 [redacted] US FOIA (b)(6) [redacted] observed.

During the chart review, the surveyor could not find any nursing Ex Order 26.4B1 [redacted] documentation by nursing for daily Ex Order 26.4B1 [redacted] care, only consultant documentation was noted.

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On 4/20/2023 at 11:33 AM, the surveyor interviewed the [redacted] who performed the [redacted] care for Resident #114. The surveyor asked her why she did not sign off the [redacted] care in the eMAR, as she was observed performing it. The [redacted] responded, "I don't know why, I never do. A [redacted] care note is not documented daily when I do treatment care on the resident."

On 4/20/2023 at 11:40 AM, the surveyor interviewed the residents assigned [redacted] who signed the eMAR and documented that she performed the [redacted] treatment observed by the surveyor. The [redacted] explained that she was asked to sign the eMAR by the [redacted] The [redacted] indicated, "I don't know but knew it was not right."

On 4/20/23 at 11:45 AM, the surveyor discussed her concerns with the [redacted] The [redacted] stated, "the facility expectation is to follow the policy appropriately and the prescribed order. The nurse should document and adjust the care plan as needed. The [redacted] care nurse should do the treatment, document appropriately and document what she has done. Then sign off in the eMAR. It is not appropriate to ask the staff nurse to sign off the eMAR if she did not perform the treatment."

A review of facility Charting and Documentation policy, version 1.2 (H5MAPL0124), adopted 11/2018, updated 1/2022, reviewed by the facility on 3/2023, revealed #7 Documentation of procedures and treatments will include care-specific details, including:

The date and time the procedure /treatment was provided.

The name and title of the individual(s) who

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F 658	Continued From page 21 provided care. The assessment data and /or any unusual findings obtained during the procedure/treatment. How the resident tolerated the procedure/ treatment. The signature and title of the individual documenting. A review of facility Wound Care policy, version 1.2 (H5MAPL0296), adopted 11/2018, updated 10/2019, updated 5/2021, reviewed 1/2023, revealed, section Documentation #4, the name and title of the individual performing the wound care. On 4/20/23 at 1:30 PM, the surveyor met with the [redacted] to discuss the issue involving appropriate signing of the eMAR by the treatment performing nurse. No further information was provided.	F 658		
F 677 SS=D	NJAC 8:39-27.1 (a) ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Complaint # NJ00154588 Based on observations, interviews, review of medical records, and review of other pertinent facility documents, it was determined that the facility failed to ensure that timely [redacted]	F 677	1. Resident #100 was immediately [redacted] by the CNA after providing [redacted]. 2. All incontinent residents who are dependent on staff for care are at risk for	6/16/23

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F 677	Continued From page 22 care was provided to 1 of 3 residents dependent on staff for care. This deficient practice was observed during a care tour and involved Resident #100. This deficient practice was evidenced by the following: On 4/19/23 at 11:46 AM, the surveyor conducted a care tour with the Ex Order floor US FOIA (b)(6) Resident #100 was checked for Ex Order 26.4B1 care by the Ex Order 26 floor US FOIA (b)(6). The surveyor observed Resident #100, who was lying in bed, wearing a Ex Order 26.4B1 Ex Order 26.4B1 which appeared to be Ex Order 26.4B1 Ex Order 26.4B1. There was an Ex Order 26.4B1 Resident #100 which had a Ex Order 26.4B1 Ex Order 26.4B1 The outer border of Ex Order 26.4B1 was a Ex Order 26.4B1. The Ex Order floor US FOIA (b)(6) confirmed that the Ex Order 26.4B1 was from Ex Order 26.4B On 4/19/23 at 12:00 PM, the surveyor interviewed the Ex Order 26 floor US FOIA (b)(6). The Ex Order floor US FOIA (b)(6) indicated that Resident #100's Ex Order 26.4B1 and Ex Order 26.4B1 should not have been Ex Order 26.4B1. The Ex Order floor US FOIA (b)(6) identified that residents should be checked every two hours. On 4/19/23 at 12:23 PM, the surveyor conducted an interview with the Certified Nurse Aide (CNA #1) assigned to Resident #100. CNA #1 stated that she made rounds on her assigned residents when she started her shift and that she would check the residents Ex Order 26.4B1. CNA #1 added that if the resident's Ex Order 26.4B1, she would NJ Exec Order 26.4b1 before the breakfast trays were delivered to the residents.	F 677	the same deficient practice. 3. Nursing staff were re-educated on the policy and procedure for caring for incontinent residents who are dependent on staff care. 4. The Unit Managers / Designee will conduct audits to 5 incontinent residents weekly x 3 months. Any issues identified during the audit will be addressed immediately. Audits will be reviewed through the monthly QAPI process for the next three months.	

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CNA #1 stated that she checked NJ Exec Order 26.4b1 every two hours. CNA #1 stated that she had about 10 residents on her assignment and that half of the residents were NJ Exec Order 26.4b1. She added that sometimes she had 11 residents on her assignment to care for when the unit only had 6 CNA's.

CNA #1 indicated that she checked Resident #100 around 8:30 or 9:00 AM and that the resident NJ Exec Order 26.4b1 She added that she has a routine and was NJ Exec Order 26.4b1 another resident who was Ex Order 26.4B1. CNA #1 demonstrated that she was planning on going to NJ Exec Order 26.4b1 Resident #100 after completing the previous resident.

CNA #1 explained that Resident #100 was very Ex Order 26.4B1 and should not have been left like that. She added that she tried her best to check her residents every two hours but that it does not always happen. CNA #1 confirmed that it had been more than two hours and that she had not checked the resident prior to the surveyor finding Resident #100 Ex Order 26.4B1. CNA #1 confirmed that the resident did not have any Ex Order 26.4B1

On 4/19/23 at 1:04 PM, the surveyor interviewed the US FOIA (b)(6) regarding NJ Exec Order 26.4b1 care. The US FOIA (b) stated that the residents should NJ Exec Order 26.4b1 as frequently as possible. The US FOIA (b) indicated that her expectations were that residents should not have Ex Order 26.4B1 as well as the Ex Order 26.4B1.

On 4/21/23 at 9:55 AM, the surveyor went to interview Resident #100. The surveyor was unable to interview the resident who was not in

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F 677	Continued From page 24 the facility at that time. The surveyor reviewed Resident #100's medical record. A review of the Admission Record (AR) indicated that the resident was admitted to the facility and had diagnoses which included but were not limited to Ex Order 26.4B1 [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26.4B1 reflected a Brief Interview of Mental Status (BIMS) score of [redacted] out of 15 which indicated Ex Order 26.4B1. Section [redacted] of the MDS indicated under [redacted] use that the resident required extensive assistance. Section [redacted] indicated under Ex Order 26.4B1 that the resident was NJ Exec Order 26.4b1. A review of the resident's individualized care plan reflected a focused area dated Ex Order 26.4B1, that the resident was at risk for Ex Order 26.4B1 secondary to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1. Interventions included but were not limited to: Offer [redacted] assistance upon arising, before/after meals, at bedtime and PRN. Provide [redacted] care after each NJ Exec Order 26.4b1.	F 677		

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COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD NORTH BERGEN, NJ 07047

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F 677	Continued From page 25 On 4/20/23 at 1:53 PM, in the presence of the [US FOIA (b)(6) redacted] from another facility, the surveyor discussed their concern that the [NJ Exec Order 26.4b] care for Resident #100 was not performed in a timely manner during their observation. A review of the facility provided policy titled, "Urinary Continence and Incontinence-Assessment and Management" with a revised date of September 2010 included the following: 1. The staff and practitioner will appropriately screen for, and manage, individuals with urinary incontinence. 2. Management of incontinence will follow relevant clinical guidelines. 3. The physician and staff will provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. The policy did not include how often incontinence care would be provided. A review of the facility provided policy titled, "Activities of Daily Living (ADL's), Supporting" with an updated date of 10/2021, included the following, "Policy Statement: Residents will [be] provided with care, treatment, and services as appropriate to maintain or improve their ability to carry activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene." Review of the Policy Interpretation and	F 677		

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F 677	Continued From page 26 Implementation section documented, "2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: ...c. Elimination (toileting); ..." On 4/21/23 at 12:54 PM, in the presence of the US FOIA (b)(6) from another facility and the survey team, the US FOIA (b)(6)) shared that the minimum time for NJ Exec Order 26.4b1 care was every two hours and more frequently if needed. No further information was provided. N.J.A.C. 8:39-27.1 (a)	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medical record and other facility documentation, it was determined that the facility failed to follow and maintain NJ Exec prevention interventions documented on the resident's care plan (CP) for 1 of 2 residents reviewed for Ex Order 26 Resident #119.	F 689	1. The NJ Exec Order 26.4b1 of Resident #119 was NJ Exec Order 26.4b1 on the floor. 2. All residents high risk for falls that are care planned to use the floor mats are at risk for the same deficient practice.	6/16/23

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F 689	Continued From page 27 The deficient practice was evidenced by the following: On 4/10/2023 at 12:21 PM, the surveyor observed the resident in NJ Exec Order 26.4b1 with the Ex Order 26.4B1 NJ Exec Order 26.4b1 off the floor and leaning against the bed rail. On 4/11/2023 at 12:22 PM, the surveyor observed the resident in NJ Exec Order 26.4b1 with the Ex Order 26.4B1 NJ Exec Order 26.4b1 off the floor and once again leaning against the bed rail. A review of the Admission Record face sheet (an admission summary) indicated that the resident had diagnoses which included but was not limited to Ex Order 26.4B1 [redacted] A review of the Quarterly Minimum Data Set (MDS), an assessment tool, dated Ex Order 26.4B1 The resident had a brief interview for mental status (BIMS, cognitive screening measure that focuses on orientation and short-term word recall) score coded as Ex Order 26.4B1 of 15 indicating they had a Ex Order 26.4B1 [redacted] A review of the residents CP with an initiated date of NJ Exec Order 26.4b1 and revised on NJ Exec Order 26.4b1, reflected that the resident was at risk for Ex Order 26.4B1 NJ Exec Order 26.4b1 to NJ Exec Order 26.4b1 and NJ Exec Order 26.4b1 [redacted] Interventions reflect NJ Exec Order 26.4b1 at bedside initiated on NJ Exec Order 26.4b1	F 689	3. All staff are educated in the implementation in maintaining fall interventions per resident□s individualized plan of care. 4. The ADON / Designee will audit 5 residents with floor mats weekly x3 months. Any issues identified will be addressed immediately. Audits will be reviewed through the monthly QAPI process for the next three months.	

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F 689	Continued From page 28	F 689		

A review of the resident's orders dated [redacted] indicated that the order was active. The order reads, [redacted] when resident in bed, check placement every shift."

On 4/18/2023 at 10:37 AM, the surveyor interviewed the [redacted]) responsible for the care of Resident #119. The [redacted] informed the surveyor, [redacted] are used for safety. When the resident is in bed they are always supposed to be on the floor. The [redacted] added that the proper positioning for [redacted] is next to the bed. In addition the [redacted] explained, "when the resident is in the [redacted] both [redacted] should be down, both [redacted] should be flat, only if staff is with resident and resident is in bed could it be up."

On 4/18/2023 at 11:10 AM, the surveyor interviewed the [redacted]) who stated, "when we identify a patient, the facility puts the [redacted] in the room to [redacted], then the patient will be care planned for it. The only time the [redacted] should not be down is if the patient is eating because the bedside table cannot roll under bed if [redacted] are down, or a visitor is in the room at bedside."

A review of the Falls Risk Evaluation policy, provided by the [redacted] on 4/18/2023 at 12:23 PM, under section labeled Policy: The Fall Risk Evaluation (completed on admission) will determine fall risk factors. The intradisciplinary team identifies and implements appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and independence. Under the section labeled Procedure:
2) Implement goal and interventions with resident /patient/family for inclusion in the intradisciplinary

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F 689	Continued From page 29 plan of care (IPOC) based on individual needs. On 4/18/2023 at 1:00 PM, the surveyor met with [redacted] to discuss the deficient practice. No further information was provided. N.J.A.C. 8:39-27.1 (a)	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to: a) maintain [redacted] care and services for a resident who was receiving an [redacted] treatment according to the standards of practice. The deficient practice was identified for 2 of 4 residents, Resident #382 and #114 reviewed for [redacted] care. This deficient practice was evidenced by the following: a) On 4/10/23 at 12:56 PM, during the initial tour, the surveyor observed Resident #382 sitting in their wheelchair with [redacted] in use [redacted]	F 695	1. Resident #114 concerns were immediately addressed. The [redacted] was educated to ensure to follow protocol by notifying the [redacted] of the resident□s concerns. 2. All residents requiring suctioning and respiratory equipment have the potential to be affected by the same deficient practice. 3. Education was provided to nursing and respiratory staff for appropriate storage of nasal cannula / tubing when not in use	6/16/23

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F 695	Continued From page 30 Ex Order 26.4B1) attached to a Ex Order 26.4B1 (Ex Order 26.4B1 . The Ex Order 26.4B1 . On 4/18/23 at 11:58 AM, the surveyor observed Resident #382 not in their room. The surveyor observed a Ex Order 26.4B1 on the floor, dated NJ Exec Order 26.4, not in use, and connected to the Ex Order 26.4B1 The surveyor reviewed Resident #382's medical record that revealed the following: The Face Sheet revealed that Resident #382 was admitted to the facility with diagnoses that included but not limited to Ex Order 26.4B1 The Admission Minimum Data Set, an assessment tool used to facilitate the management of care, with an Assessment Reference Date of Ex Order 26.4B1, revealed a Brief Interview Status score of Ex Order out 15, which indicated that the resident was Ex Order 26.4B1 A further review in Section NJ E. Treatment and Procedures, indicated that the resident received Ex Order 26.4B1 . The NJ Ex Order 26.4b1 Physician Order Report revealed the following: Ex Order 26.4B1 continues every shift" with a start date of Ex Order 26.4B1 and a discontinued date of Ex Order 26.4B . Ex Order 26.4B1 via every shift as needed (PRN) for Ex Order 26.4B1)" with a start date of Ex Order 26.4B1 and a discontinued date of Ex Order 26.4B1 .	F 695	and to document in progress notes. 4. The Unit Manager/ Designee will conduct an audit of 3 residents x 3 months, to ensure that oxygen cannulas/ tubings are placed in plastic bags when not in use and residents□ concerns are immediately addressed. Audits will be reviewed through the monthly QAPI process for the next three months.	

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On 4/18/23 at 12:00 PM, the surveyor brought the US FOIA (b)(6) inside the resident's room. During the interview, the US FOIA (b)(6) acknowledged that the NJ Exec Orde should have been placed inside a plastic bag when not in use for proper storage, she stated, "It shouldn't have been on the floor."

A review of the facility policy titled, "Departmental (Respiratory Therapy)-Prevention of Infection" with a review date of 2/2023 under "Purpose: The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment." The policy further indicated under "Infection Control Considerations Related to Oxygen Administration: 5. Keep the oxygen cannula and tubing used PRN in a plastic bag when not in use."

On 4/21/23 at 1:08 PM, the team met with the US FOIA (b)(6). The surveyor verbalized the above concern. The US FOIA (b)(6) acknowledged that the NJ Exec Order 26.4b1 should have been placed inside a plastic bag when not in use.

b) On 4/19/2023 at 11:10 AM, the surveyor observed Ex Order 26.4B1 care on Resident #114, who was observed having an Ex Order 26.4B1 of their Ex Order 26.4B1

On 4/19/2023 at 11:28 AM, after Ex Order 26.4B1 care the resident requested to speak privately with the surveyor. Resident #114 had Ex Order 26.4B1, so they Ex Order 26.4B1 . The

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surveyor proceeded to have a Ex Order 26.4B1 Ex Order 26.4B1 with the resident. Resident #114 communicated with the surveyor via Ex Order 26.4B and Ex Order 26.4B1 (with Ex Order 26.4B1) their needs.

On 4/19/2023 at 11:33 AM, the surveyor interviewed Resident #114, who informed the surveyor that they had sought out help from the US FOIA (b)(6) NJ Exec Order 26.4b1 US FOIA) by informing him that they NJ Exec Order 26.4b1 . Resident #114 wrote out, Ex Order 26.4B1 Ex Order 26.4B1 . Ex Order 26.4B1 Ex Order 26.4B1 The resident explained that they informed, Ex Order 26.4B1 which was the Ex Orde floor Ex Order 26.4B1 unit.

A review of Resident #114's Admission Record (AR) indicated that they were admitted to the facility with diagnoses which included but were not limited to Ex Order 26.4B1

A review of the Quarterly MDS dated Ex Order 26.4B1 revealed a BIMS score of NJ Exe of 15. This score suggested that Resident #114 had Ex Order 26.4B Ex Order 26.4B1 .

A review of the Comprehensive Care Plan with an

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F 695	Continued From page 33 admission date of Ex Order 26.4B1, revealed ... ~at risk for Activities of daily living (ADL) decline, dated Ex Order 26.4B1NJ. with an intervention in place is to have a NJ Exec Order 26.4b1 [redacted] ~is on a Ex Order 26.4, (Ex Order 26.4B1 [redacted]) as ordered and dated on Ex Order 26.4B1 with an intervention to Ex Order 26.4B1 as needed and every shift by the US FOIA and nurse. A review of the electronic Medication Administration Record (eMAR), dated Ex Order 26.4B1 through Ex Order 26.4B1, revealed a Physician's Order (PO) dated Ex Order 26.4B1, 'Ex Order 26.4B1 [redacted] A review of the Progress Notes dated Ex Order 26.4B1 through Ex Order 26.4B1 did not reveal any documentation from the US FOIA stating that the resident had told him of their concerns regarding NJ Exec Order 26.4b1. There was no documentation from the US FOIA that anyone else was made aware of the concerns that Resident #114 was experiencing, including the US FOIA (b)(6) On 4/19/23 at 12:14 PM, the surveyor interviewed the US FOIA (b)(6)). Who stated, "I am unaware of Resident #114 having Ex Order 26.4B1 Ex Order 26.4B1 The Resident has not discussed specifically with me about moving to the Ex Orde floor." On 4/19/23 at 12:52 PM, the surveyor interviewed the US FOIA (b)(6) [redacted]. The US FOIA (b)(6) stated, "I am unaware of any Ex Order 26.4B1 issues. I have not been informed by the US FOIA that Resident #114 requested Ex Order 26.4B1	F 695		

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F 695	Continued From page 34 On 4/19/2023 at 12:33 PM, the surveyor interviewed the [US FOIA (b)(6)] The [US FOIA (b)] informed the surveyor, "I was unaware of the resident having Ex Order 26.4B1. It was never brought to my attention that the resident wanted to move to the [Ex Order 26.4B1]. The only request I was informed of was that Resident #114 Ex Order 26.4B1 which we have recently gotten them." On 4/19/23 at 1:48 PM, the surveyor interviewed the [US FOIA] who stated, "The resident has stated that they were Ex Order 26.4B1, and I told the staff on the floor to call me, and I will come down to Ex Order 26.4B1. The surveyor asked the [US FOIA] if he informed his supervisor, the [US FOIA (b)] or the [US FOIA (b)(6)] of the resident's Ex Order 26.4B1? The [US FOIA] stated, "No, I have not. I did tell the resident I would try to Ex Order 26.4B1." The [US FOIA] indicated that nothing was documented referring to his discussions with Resident #114 or in reference to the resident's concerns. A review of facility Charting and Documentation policy, version 1.2 (H5MAPL0124), adopted 11/2018, updated 1/2022, reviewed by the facility on 3/2023, revealed #7 Documentation of procedures and treatments will include care-specific details, including: The date and time the procedure /treatment was provided. The name and title of the individual(s) who provided care. The assessment data and /or any unusual findings obtained during the procedure/treatment. How the resident tolerated the procedure/ treatment. The signature and title of the individual documenting.	F 695		

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A review of the Oxygen administration policy adopted 11/2018, revised 10/2020, and updated by the facility on 10/2019 revealed under reporting section #2- Report other information in accordance with facility policy and professional standards of practice.

A review of the facility Employee Lease agreement between the Hospital Medical Center and the facility, states that the [US FOIA] is an employee of the hospital and leased to the facility for respiratory care services. The agreement was signed by the President of the hospital and dated on 3/16/2023.

The surveyor reviewed the original contract for the lease of the US FOIA (b)(6) dated NJ Exec Order 26.4b1 signed by the US FOIA (b)(6) . It states in the body of the agreement: "technical management oversight by our US FOIA (b)(6) at the Medical Center."

The [US FOIA] failed to follow up with the Ex Order 26.4B1 that Resident #114 was experiencing discussed with him. The [US FOIA] failed to follow protocol by notifying the US FOIA (b)(6) US FOIA (b)(6), the facility's [US FOIA (b)] or [US FOIA (b)(6)] of the resident's concerns, care, or alterations in medical issues that Resident #114 was experiencing and discussed with him.

The [US FOIA] did not follow up with a progress note on the resident's chart documenting the issues that Resident #114 was having. There was no documentation or verbal discussions provided to the surveyor relaying that any of the discussions that Resident #114 had with the [US FOIA] took place.

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F 695	Continued From page 36 On 4/21/23 at 12:54 PM, in the presence of the US FOIA (b)(6) from another facility, the survey team further discussed the issue surrounding Resident #114's NJ Exec Order 26.4b1 concerns and the request to move to another unit that provided a higher level of care. No further information was provided.	F 695		
F 725 SS=D	NJAC 8:39-4.1 (a) 5 Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		6/16/23

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F 725	Continued From page 37 paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Complaint # NJ00154588 Based on observation, interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide sufficient nursing staff to ensure resident's highest practical wellbeing by failing to: a.) provide NJ Exec Order 26.4b1 care in a timely manner, b.) maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 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 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	F 725	1. 1. NJ Exec Order 26.4b1 care was provided to Resident #100 upon notification from the surveyor that care needed to be rendered. The facility□s CNA staffing ratio was adjusted equally on all the floors to cover the call outs to reach the regulation of 1:8 CNA ratio. 2. All incontinent residents□ dependent on staff for care have the potential to be affected by the same deficient practice. 3. All Nurses / CNAs were educated on the policy and procedure related to providing incontinent care to residents□ dependent on staff care. Staffing coordinator and Nurse managers were educated to maintain the required minimum direct care staff to shift ratios as mandated by the state of NJ. 4. Unit Manager will audit 3 residents who are dependent to staff care weekly x4 weeks then monthly x2 months. Result of audit will be submitted during QAPI meeting monthly. The DON and / Designee will review the daily staffing assignments to ensure continued compliance. Any trends/ issues identified will be addressed immediately. Result will be reviewed during QAPI meeting monthly.	

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	315307	A. BUILDING _____ B. WING _____	04/26/2023

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F 725	Continued From page 38 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. On 4/19/23 at 11:46 AM, the surveyor conducted a care tour with the Ex Order floor US FOIA (b)(6) Resident #100 was checked for Ex Order 26.4B1 by the Ex Order 2 floor US FOIA (b)(6). The surveyor observed Resident #100, who was lying in bed, wearing a Ex Order 26.4B1 Ex Order 26.4B1 which was Ex Order 26.4B1 . There was an NJ Exec Order 26.4b1 Resident #100 which had a Ex Order 26.4B1 on it. The outer border of the Ex Order 26 was a Ex Order 26.4B1 Ex Order 26.4B1. The Ex Order floor US FOIA (b)(6) confirmed that the NJ Exec Order 26.4b1 The NJ Exec O floor US FOIA (b)(6) explained that Resident #100's Ex Order 26.4B1 and NJ Exec O underneath should not have been Ex Order 26.4B1 . She explained that the resident's CNA was taking care of another resident and hadn't gotten to care for Resident #100 yet. The Ex Order floor US FOIA (b)(6) verified that residents should be checked every two hours for need of care. She added that the residents had breakfast and now the CNAs were taking care of them. The Ex Order floor US FOIA (b)(6) specified that there was seven CNAs on the unit that day. The US FOIA (b)(6) indicated that the CNAs had nine residents, and some had ten residents to care for. She then added that sometimes the unit had eight CNAs and sometimes six CNAs. The surveyor requested the CNA assignment sheet. A review of the 7:00 to 3:00 PM consisting of 7 CNA's Assignment sheet dated 4/19/23 included	F 725		

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the following:
Assignment 1, 2 and 3 had 10 residents each
Assignment 4 and 5 had 9 residents each
Assignment 6 and 7 had 8 residents each with 1 resident on each of those assignments marked with a black line through it which indicated that there was not a resident in that bed that needed to be cared by.
CNA #1 (The CNA assigned to care for Resident #100) was listed under Assignment 4 with 9 residents.

On 4/19/23 at 12:23 PM, the surveyor conducted an interview with the CNA #1, assigned to Resident #100. CNA #1 stated that she made rounds on her assigned residents when she started her shift and that she would check the residents' Ex Order 26.4B1 and if their Ex Order 26.4B Ex Order 26.4B1, she would Ex Order 26.4B1 them before the breakfast trays were delivered to the residents.

CNA #1 stated that she checked the resident and their Ex Order 26.4B1 every two hours. CNA #1 informed the surveyor that she had about ten residents and that half of the residents were Ex Order 26.4B1 She added that sometimes she had eleven residents on her assignment when the unit only had six CNAs.

CNA #1 identified that she checked Resident #100 around 8:30 or 9:00 AM and that the resident NJ Exec Order 26.4B She added that she has a routine and was NJ Exec Order 26.4b1 another resident who was Ex Order 26.4B before returning to NJ Exec Order 26 Resident #100.

CNA #1 revealed that Resident #100 was "Ex Order 26.4 Ex Order 26.4B" and should not have been left like that. She added that she tries her best to check her

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F 725	Continued From page 40 residents every two hours but that it does not always happen. CNA #1 confirmed that it had been more than two hours and that she had not checked the resident prior to the .surveyor finding the resident On 4/19/23 at 12:35 PM, the surveyor interviewed the Ex Order floor US FOIA (b)(6) regarding staffing and the ratio of residents to CNA. The Ex Order floor US FOIA (b)(6) stated that there was a staffing coordinator who determines staffing needs. She indicated that she was not sure of the staffing ratio mandate. On 4/19/23 at 1:04 PM, the surveyor interviewed the US FOIA (b)(6)) regarding NJ Exec Order 26.4b1 care and staffing. The US FOIA (b) stated that the expectation was for staff to perform NJ Exec Order 26.4b1 care and NJ Exec Order 26. residents as frequent as possible. The US FOIA (b) informed the surveyor that there was a staffing coordinator and that they try to staff the building with as many CNAs as possible per unit. The US FOIA (b) stated that she was aware of the mandated ratio of staff to residents. The US FOIA (b) added that they try to have eight residents per CNA on the day shift but that sometimes there are callouts. The US FOIA (b) revealed that two CNAs called out in the morning. The surveyor reviewed the Nursing Home Resident Care Staffing Report posted on the Receptionist Desk. The Staffing Report included the following: 4/19/2023-Day shift Shift Hours: 7:00 AM-3:00 PM Current Resident Census:167 Certified Nurses Aide (CNA) # of Staff: 30; Total hours Worked: 240.00; Staff to Resident Ratio: 1	F 725		

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F 725	Continued From page 41 CNA: 5.6 Residents On 4/21/23 at 9:59 AM, the surveyor interviewed the US FOIA (b)(6)) regarding the process for staffing. The US FOIA stated that she staffed the building with CNAs per unit. She then stated that if she was under the mandated ratio, she would call in agency staff to meet the needed staff numbers. The US FOIA stated that she was aware of the mandated staffing ration, "it was eight residents for 1 CNA." The US FOIA stated that if staffing is found to be under the mandated ratio she would notify the US FOIA (b)(6) [redacted] The surveyor asked the US FOIA to explain the posted Staffing report for Ex Order 28.4B1 that had a ratio of 5.6 residents for 1 CNA when the Ex Order floor was found to have an assignment of nine or ten residents per 1 CNA. The US FOIA explained that she counts all the CNAs in the building and calculates the ratio by the facility census. The US FOIA explained that she was directed to count all the CNAs in building, including CNAs that were not given assignments to care for residents. She added that she was a CNA and was counted in the total number of CNAs Staffing Ratio. In addition, the US FOIA explained that the Functional Maintenance Program CNAs (provide services to optimize and maintain a client's performance after they are discharged from therapy) were also counted in calculating the Staffing Ratio. She revealed that those CNAs did not have resident assignments but that they can help feed residents and sometimes do care. The US FOIA explained that the purpose of the Staffing	F 725		

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Ratio was to give residents proper care and have enough staff to comply with resident's need. She revealed that with frequent staffing callouts the staffing ratio is frequently below the standard amount. The [redacted] explained that she reviews each unit and will call staff in to work. The [redacted] stated that she was not sure why this was not the process for the [redacted] floor on [redacted].

On 4/21/23 at 10:59 AM, the surveyor interviewed the [redacted] in the presence of a [redacted] from another facility and the [redacted] regarding the process for staffing. The [redacted] stated that they try to staff each unit based on the census on that unit.

The [redacted] was aware of the mandated ratios. She stated that the facility tries their best to staff according to the ratio. The [redacted] explained that the posted Staffing Ratio included all CNAs in the building, even CNAs that did not have assignments but go to the units to help with feeding and care. The [redacted] added that the posted number was an average for the CNAs in the entire building.

The [redacted] stated that the facility goal is to at least meet the ratio for CNA assignments. The [redacted] stated that she was not aware of the CNA ratio on the [redacted] floor unit having nine or ten residents per CNA on [redacted].

On 4/21/23 at 1:05 PM, the surveyor, in the presence of the survey team, further discussed the concern that the [redacted] floor unit had CNAs assigned to nine and ten residents and that the facility was reporting and posting that ratio of resident to CNA was 5.6 residents with the [redacted] and [redacted]

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F 725	Continued From page 43 The facility did not provide any additional information. As per the "Nurse Staffing Report" completed by the facility for the weeks of 5/01/2022 to 5/07/2022 and 5/08/2022 to 5/14/2022, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts, deficient in CNAs to total staff on 1 of 14 evening shifts, and deficient in total staff for residents on 1 of 14 overnight shifts as follows: -05/01/22 had 19 CNAs for 184 residents on the day shift, required 23 CNAs. -05/02/22 had 21 CNAs for 184 residents on the day shift, required 23 CNAs. -05/06/22 had 20 CNAs for 180 residents on the day shift, required 22 CNAs. -05/07/22 had 13 CNAs for 180 residents on the day shift, required 22 CNAs. -05/08/22 had 13 CNAs for 180 residents on the day shift, required 22 CNAs. -05/08/22 had 10 CNAs to 22 total staff on the evening shift, required 11 CNAs. -05/09/22 had 20 CNAs for 180 residents on the day shift, required 22 CNAs. -05/10/22 had 20 CNAs for 180 residents on the day shift, required 22 CNAs. -05/11/22 had 20 CNAs for 180 residents on the day shift, required 22 CNAs.	F 725		

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F 725	Continued From page 44 -05/12/22 had 11 total staff for 180 residents on the overnight shift, required 13 total staff. -05/13/22 had 20 CNAs for 182 residents on the day shift, required 23 CNAs. -05/14/22 had 18 CNAs for 179 residents on the day shift, required 22 CNAs. A review of the facility provided policy titled, "Staffing" with a revised date of October 2017, included the following: Policy Statement Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Policy Interpretation and Implementation 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services. 2. Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care or applicable federal/state laws ... 4. Direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system on the schedule specified by CMS, but no less than once a quarter. 5. Inquiries or concerns relative to our facility's staffing should be directed to the Administrator or his/her designee. N.J.A.C. 8:39-27.1 (a)	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		6/16/23

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F 755	Continued From page 45 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to hold a medication used to treat [NJ Exec Order 26.4b1] [redacted] in accordance with physician orders.	F 755	1. The Licensed Nurses were re-educated to follow the medication parameter orders.	

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F 755	Continued From page 46 This deficient practice was identified for 2 of 34 residents reviewed for medication management (Resident #124, Resident #92). The evidence was as follows: 1.) On 4/10/23 at 10:35 AM, the surveyor observed Resident #124 in the room with eyes closed. The resident was NJ Exec Order 26.4b1. The surveyor reviewed Resident #124's medical record. The resident was admitted to the facility on Ex Order 26.4B1 with diagnoses that included but not limited to Ex Order 26.4B1 A review of the electronic Physician Orders for NJ Exec Order 26.4b1 reflected a physician order (PO) with a start date of NJ Exec Order 2 for a medication, Ex Order 26.4B1 Ex Order 26.4B1. The order specified to give Ex O tablet of Ex Ord Ex Order 26.4B1) every Ex Orde hours for Ex Order 26.4B1 and to hold the medication for a Ex Order 26.4B1 NJ Exec Order 26.4b1 A review of the electronic Medication Administration Record (eMAR) for Ex Order 26.4B1 through Ex Order 26.4B1 reflected for the medication Ex Order 26.4B1 was to be administered at 9:00 AM and 9:00 PM. The eMAR revealed that the Ex Order 26.4B1 was signed as given when the resident's NJ Exec Order 26.4b1. Review of the Ex Order 26.4B1 eMAR showed that the medication was administered Ex Order 26.4B1, Ex Order 26.4B1 Ex Order 26.4B showed that the medication was administered NJ Exe times and Ex Order 26.4B1 showed that the medication was administered NJ times. 2.) On 4/10/23 at 12:30 PM, the surveyor observed Resident #92 in the room with eyes	F 755	2. All residents with hold parameter orders are at risk for the same deficient practice. 3. Licensed Nurses were re-educated and competencied on Medication Administration Policy to ensure that the hold parameter orders are followed. 4. Staff Educator / Designee will conduct audits to 3 licensed nurses during medication administration weekly x 3 months to ensure hold order parameters are followed and to address findings if any. Audits will be reviewed through the monthly QAPI process for the next three months.	

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F 755	Continued From page 47 closed. The resident was Ex Order 26.4B1 The surveyor reviewed Resident #92's medical record. The resident was admitted to the facility on Ex Order 26.4B1 with diagnoses that included but not limited to Ex Order 26.4B1 A review of the electronic Physician Orders for Ex Order 26.4B1 reflected a PO with a start date of Ex Order 26.4B1 for a medication, Ex Order 26.4B1. The order specified to give Ex O tablet of Ex Order 26.4B1 every Ex Ord hours for Ex Order 26.4B1 and to hold the medication for a Ex Order 26 NJ Exec Order 26.4b1 A review of the eMAR for Ex Order 26.4B1 through Ex Order 26.4B1 reflected for the medication Ex Order 26.4B1 was to be administered at 9:00 AM and 9:00 PM. The eMAR revealed that the Ex Order 26.4B1 was signed as given when the resident's NJ Exec Order 26.4b1. Review of the Ex Order 26.4B1 eMAR showed that the medication was administered Ex O times, Ex Order 26.4B1 Ex Order 26 showed that the medication was administered NJ times and Ex Order 26.4B1 showed that the medication was administered Ex O time. On 4/21/23 at 1:15 PM, the surveyor informed the US FOIA (b)(6) and the US FOIA (b)(6) in the presence of the survey team who both acknowledged that the eMAR was signed to reflect that the resident received the Ex Order 26.4B1 Ex Order 26.4B1 when his/her NJ Exec Or was below the hold parameters according to the PO from Ex Order 26.4B1 Ex Order 26 through Ex Order 26.4B1. They were unable to provide additional documentation as to why the nurses administered the medication without regard to the physician orders.	F 755		

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F 755	Continued From page 48 NJAC 8:39- 29.2 (d)	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain a medication rate error below 5%. The surveyor observed 2 nurses administer 26 doses of medication to 3 residents and there were 3 errors which resulted in a medication error rate of 11.50 %. The deficient practice was evidenced by the following: 1. On 4/18/23 at 8:45 AM, during the medication administration observation (med pass), the Surveyor observed the [redacted] Floor [redacted] preparing [redacted] medications for administration to a [redacted]) resident, Resident #92. The [redacted] opened a packet prepared by the pharmacy, marked for 9:00 AM administration that included [redacted] medications, [redacted] to be administered every [redacted] hours Hold if [redacted] ([redacted] and [redacted] twice daily. The Surveyor noted that the [redacted] referred to a paper that contained handwritten room numbers and vitals for numerous residents, including	F 759	1. The [redacted] that were observed by the Surveyor during med pass on Resident #92 and Resident#228 were educated on the process of checking [redacted] prior to administration for compliance of physician ordered parameters. 2. All residents receiving anti-hypertensive medications having hold order parameters are at risk for the same deficient practice. 3. Licensed Nurses were reeducated and competencied on the policy and procedure during medication administration including hold parameters. 4. The Staff Educator / Designee will observe 5 License Nurses weekly for 3 months during their medication pass to ensure they are following the policy and procedure for Medication Administration. Issues identified during the audit will be discussed with the nurse. Audits will be reviewed through the monthly QAPI process for the next three months.	6/16/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 759	Continued From page 49 Resident #92. The paper documented a [NJ Exec Or] of [Ex Order 26.4B1] for Resident #92. When asked the [US FOIA] could not give an accurate time that she took Resident #92's vitals. On 4/18/23 at 9:13 AM, as the [US FOIA] was preparing to administer the medication to Resident #92, the surveyor requested that the [NJ Exec Or] be checked. The [US FOIA] agreed and the [NJ Exec Or] was [Ex Order 26.4B1] The [US FOIA] was interviewed after the administration of the medication to Resident #92. The [US FOIA] agreed that the [NJ Exec Or] should be checked just prior to the preparation and administration of medication to the resident when a parameter is ordered by the Physician. Review of Resident #92's Face Sheet (admission summary) indicated that the resident was admitted with diagnoses that included but were not limited to[Ex Order 26.4B1] [Ex Order 26.4B1]. A review of the most recent Quarterly Minimum Data Set (MDS) an assessment tool used to facilitate the management of care, dated [Ex Order 26.4B1] identified that Resident #92 should not have a BIMS evaluation as the resident's [Ex Order 26.4B1] 2. On 4/18/23 at 10:06 AM, during the med pass, the Surveyor observed the [Ex Order] floor [US FOIA (b)(6)] preparing whole medication for administration to Resident #228. The [US FOIA (b)] opened a packet prepared by the pharmacy, marked for 9:00 AM administration that contained two medications that had physician's orders which included parameters,	F 759		

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	315307	A. BUILDING _____ B. WING _____	04/26/2023

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COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD NORTH BERGEN, NJ 07047

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F 759	Continued From page 50	F 759		

Ex Order 26.4B1 Ex Order 26.4B1
Ex Order 26.4B1

The Surveyor noted that the US FOIA (b) referred to a paper that contained handwritten room numbers and vitals for numerous residents, including Resident #228. The paper documented a NJ Exec Ord of Ex Order 26.4B1 and a HR of Ex Ord for Resident #228. When asked the US FOIA (b) could not give an accurate time that she took Resident #228's vitals.

On 4/18/23 at 10:15 AM, prior to the administration of the medication to Resident #228, the surveyor requested that the NJ Exec Ord and NJ Exec be checked. The US FOIA (b) rechecked the vitals which resulted in the NJ Exec Ord for Resident #228 being Ex Order 26.4B1 and the NJ Exec Ex Orde
The US FOIA (b) continued to administer both medications to Resident #228.

The US FOIA (b) was interviewed after the administration of the medication to Resident #228. The US FOIA (b) agreed that the NJ Exec Or and NJ Exec should be checked just prior to preparation and administration of medication to the resident when parameters are ordered by the Physician. The US FOIA (b) agreed that she should not have administered the Ex Order 26.4B1 Ex Order 26 to Resident #228, as the NJ Exec Ord was Ex Order 26 prior to administration and the physician's order documented that the medication should be held if the Ex Order 26.4B1

Review of Resident #228's Face Sheet (admission summary) indicated that the resident was admitted with diagnoses that included but were not limited to Ex Order 26.4B1

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F 759	Continued From page 51	F 759		

Ex Order 26.4B1 [redacted].

Review of Resident #228's Admission MDS dated Ex Order 26.4B1 identified that Resident #228 had a BIMS o[redacted] indicating that the resident was NJ Exec Order 26.4b1 [redacted].

Review of Resident #228's Care Plan (CP) describes that the resident, "has Ex Order 26.4B1 [redacted] related toEx Order 26.4B1 [redacted] NJ Exec Order 26.4b1 [redacted]" In addition the CP documented that the resident, NJ Exec Order 26.4b1 [redacted]."

Review of the Administering Medications Policy, under the Policy Interpretation and Implementation indicated:

2. Medications must be administered in accordance with the orders, including any required time frame.

6. The following information must be checked/verified for each resident prior to administering medications

b. Vital signs, if necessary

On 4/18/23 at 1:47 PM , the surveyor met with the US FOIA (b)(6) [redacted] to discuss the results of the observation of morning med pass. The [redacted] acknowledged that when there are medications ordered with parameters by the physician, the vitals should be checked just before preparing the resident's medication.

NJAC 8:39-29.2 (d)

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F 836	Continued From page 52	F 836		
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents it was determined	F 836	1. All signage and policies with the Complete Care at Harborage logo were	6/16/23

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F 836	Continued From page 53 that the facility failed to notify CMS (Centers for Medicare & Medicaid Services) and receive authorization for a change in facility name in accordance with 42 CFR (Code of Federal Regulations) 424.516. This deficient practice was evidenced by the following: According to 42 CFR 424.516 Additional provider and supplier requirements for enrolling and maintaining active enrollment status in the Medicare Program: "(a) Certifying compliance. CMS enrolls and maintains an active enrollment status for a provider or supplier when that provider or supplier certifies that it meets, and continues to meet, and CMS verifies that it meets, and continues to meet, all of the following requirements: (1) Compliance with title XVIII of the Act and applicable Medicare regulations. (2) Compliance with Federal and State licensure, certification, and regulatory requirements, as required, based on the type of services, or supplies the provider or supplier type will furnish and bill Medicare. (3) Not employing or contracting with individuals or entities that meet either of the following conditions: (i) Excluded from participation in any Federal health care programs, for the provision of items and services covered under the programs, in violation of section 1128 A(a)(6) of the Act. (ii) Debarred by the General Services Administration (GSA) from any other Executive Branch procurement or nonprocurement programs or activities, in accordance with the Federal Acquisition and Streamlining Act of 1994,	F 836	replaced to reflect the legal name Harborage, The". 2. All residents have the potential to be affected by the same deficient practice. 3. Staff were educated on the requirement to only use the legal facility name as recognized by CMS and NJ Department of Health □ Harborage, The. 4. Administrator and / or designee will conduct weekly audits of the facility to ensure CMS and NJDOH approved name of Harborage, The is displayed.	

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F 836	Continued From page 54 and with the HHS Common Rule at 45 CFR part 76..... (d) Reporting requirements for physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations. Physicians, nonphysician practitioners, and physician and nonphysician practitioner organizations must report the following reportable events to their Medicare contractor within the specified timeframes: (1) Within 30 days - (i) A change of ownership; (ii) Any adverse legal action; or (iii) A change in practice location. (2) All other changes in enrollment must be reported within 90 days." On 4/10/23 at 9:00 AM, upon arrival of the surveyors to the facility, the surveyor observed a facility sign, "Complete Care at the Harborage" that had a name that did not correspond with the CMS licensed, approved name and provider registered name "The Harborage." Once the survey team entered the facility, there were numerous displayed signs with the same name "Complete Care at the Harborage." The facility name displayed on the entrance area of the facility and in the administration office area, "Complete Care at the Harborage" did not correspond with the CMS(Center for Medicaid and Medicare Services) licensed and approved name of "The Harborage." On 4/10/23 at 10:43 AM, the State Surveyor met with the US FOIA (b)(6) for Entrance Conference. During the discussion the facility US FOIA (b)(6) informed the surveyor that the facility was	F 836		

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F 836	Continued From page 55 purchased by Complete Care in March 2023 and, "that's when the facility name changed." On 4/11/23 at 11:16 AM, the surveyor reviewed various documents and facility policies that were provided by the US FOIA (b)(6) that were titled, "Complete Care at the Harborage." The documents provided showed that the facility name currently in use did not match the facility's licensed name. The facility name, "Complete Care at the Harborage" utilized was not approved by CMS. The Surveyor reviewed the facility license which documented, "Harborage, The" as the facility name. The license issued by the New Jersey Department of Health (NJDOH) Division of Certificate of Need and Licensing was issued on 2/28/23 and expired on 2/29/24. On 4/17/23 at 10:40 AM, the state surveyor met with the US FOIA (b)(6) who explained that an email would be sent from the company paralegal explaining the authorization of the facility name change by the Department of Health (DOH). On 4/17/23 at 11:27 AM, an email was received from the company paralegal that included an attached letter from the DOH dated October 21, 2022. The DOH letter attached explained, "The Department of Health (Department) has reviewed the applications for the transfer of ownership interests in the above mentioned facilities. Based on the application and responses to completeness questions, the Department is authorizing the above transfers of ownership to proceed." The documentation on page 4 of the DOH letter	F 836		

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F 836	Continued From page 56 stated, "Although the new owner is authorized to operate the facility following the transaction, the Department will not issue the license under the new ownership until the items listed below are received and reviewed by staff from the Department." The letter continues to list a number of items that need to be submitted for the NJDOH to issue a new license for the new owners allowing them to change the name of the facility. On 4/18/23 at 1:47 PM, the surveyor discussed the DOH letter with the US FOIA (b)(6) who stated, "No other documentation was available for name change approval only sale approval." The US FOIA (b)(6) agreed that the facility name change had not been approved and the facility license is still for The Harborage. On 4/20/23 at 1:52 PM, the Surveyor met with the facility US FOIA (b)(6) to discuss the deficient practice of utilizing the facility name Complete Care at the Harborage without NJDOH Licensure approval. No further information or documentation was provided to the survey team to refute these findings.	F 836		
F 880 SS=D	NJAC 8:39-5.1 (a) 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	F 880		6/16/23

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F 880	Continued From page 57 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: (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	F 880		

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F 880	Continued From page 58 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: Based on observation, interview, and record review, it was determined that the facility failed to maintain proper infection control practices to mitigate the spread of infection for 3 of 36 Residents observed, Resident #92, #39, and #228. The deficient practice was observed on 2 out of 4 facility floors during medication administration observation. This deficient practice was evidenced by the following: 1. On 4/18/23 at 8:45 AM, the Surveyor observed medication administration (med pass) on the [redacted] floor, [redacted] Unit performed by a US FOIA (b)(6)	F 880	1. The [redacted] that administered the medications for resident #92 was reeducated on handwashing prior to preparing medications, before putting on gloves and after removal of gloves, cleaning of the surface of overbed table before putting the [redacted] supplies, using a NJ Exec Order 26.4b1 [redacted] storing of plunger on a non-contaminated surface. The [redacted] that administered medications for Resident #39 and Resident #228 was reeducated on sanitizing/ handwashing in between residents and sanitizing stethoscope before and use.	

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F 880	Continued From page 59 ([US FOIA (b)] The State Surveyor observed the [US FOIA] prepare the [Ex Order 26.4B1] medication for a [Ex Order 26.4B1] ([Ex Order 26.4B1] dependent Resident, Resident #92 without washing her hands. The surveyor requested that the [US FOIA] check Resident #92's vitals due to the physician parameter order. The [US FOIA] proceeded to check Resident #92's vitals without sanitizing the stethoscope before or after use on this compromised Resident. The [US FOIA] put on gloves without sanitizing or washing her hands and retrieved [Ex Order 26.4] administration supplies (container filled with water and [NJ Exec Order 26.4b1]) from the resident's bathroom. The [US FOIA] placed the [Ex Order 26.4B] supplies on the Resident's over bed table without cleaning the surface. The [US FOIA] opened Resident #92's blanket, exposing the resident's [Ex Order 26.4B1] lying on a towel. The [US FOIA] removed the towel and placed it on top of the blanket. The [US FOIA] then shut Resident #92's feed and removed the [Ex Order 26.4B1] from the [Ex Order 26.4] attachment placing it on the contaminated towel. The [US FOIA] did not place a [NJ Exec Order 26.4b1] on the end of the [Ex Order 26.4B1] to protect it from contamination. On 4/18/23 at 9:36 AM, the [US FOIA] proceeded to administer the medication to Resident #92 without sanitizing/washing her hands or changing her gloves. The surveyor observed the [US FOIA] pour water into the crushed medication cups. She then poured	F 880	2. All residents are at risk for the same deficient practice. 3. Nursing staff were re-educated on handwashing policy and usage of PPE (gloves). Licensed Nurses were also re-educated on cleaning and disinfecting of multi-use equipment including stethoscope. 4. Unit managers / Designees will conduct audits of 3 Licensed Nurses during med pass weekly x 3 months to ensure they are following the policy and procedure for Handwashing and Gtube medication administration. Any issues identified during audit will be addressed immediately. Audits will be reviewed through the monthly QAPI process for the next three months.	

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F 880	Continued From page 60 the medication into the [Ex Order 26.4B] and used the plunger, stored on the contaminated towel to aide in the flow of the medication through the [NJ Exec Orde]. This process continued throughout the med pass with continued storage of the plunger on the contaminated towel and at times on the contaminated over bed table without any clean barrier used. When the [US FOIA] completed the administration of the medication to Resident #92, the surveyor interviewed the [US FOIA]. The [US FOIA] acknowledged that her administration procedure was not sanitary and could expose compromised Resident #92 to infection. The [US FOIA] stated that she should have washed her hands prior to glove use, changing gloves when they were contaminated, like touching the feeding machine or towel. The [US FOIA] realized that the overbed table and towel used were contaminated and should have not been used to store sanitary items, [NJ Exec Order 26.4b1] [redacted], and the plunger. 2. On 4/18/23 at 9:59 AM, the surveyor noted that the [Ex Order] floor [US FOIA (b)(6)] [redacted] sanitized her hands prior to preparing medication for Resident #39. The [US FOIA (b)] administered the medication to Resident #39 and continued to Resident #228 med pass without sanitizing/washing her hands. 3. On 4/18/23 at 10:06 AM, the surveyor observed the [US FOIA (b)] prepare medication for Resident #228 without sanitizing/washing her hands. The surveyor requested that the [US FOIA (b)] check Resident #228's vitals due to the physician	F 880		

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F 880	Continued From page 61 parameter orders. The [US FOIA (b)(6)] proceeded to check Resident #228's vitals without sanitizing the stethoscope before or after use on this resident. Review of the Administering Medication Policy documented as reviewed 2/2023, under 12., "Staff shall follow established facility infection control procedures (e.g, handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for administration of medications, as applicable. Review of Handwashing/Hand Hygiene Policy documented as reviewed 2/2023, under 7., "Use an alcohol-based hand rub containing at least 70% alcohol; or, alternatively, soap and water for the following situations: b. Before and after direct contact with residents; c. Before preparing or handling medications; f. Before donning sterile gloves; i. After contact with a resident's intact skin; l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves." Continued review of the Handwashing/Hand Hygiene Policy under 9. "The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." On 4/20/23 at 1:52 PM, the surveyor met with the [US FOIA (b)(6)] to discuss the infection control breaches. No further information was provided. NJAC 8:39 - 19.4(a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060907	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD 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 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and 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. This deficient practice was evidenced by the following. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General	S 560	1. All Residents have the potential to be affected by this deficient practice. 2. No Residents were affected by this deficient practice. 3. Additional per diem, part time and full time were scheduled to meet minimum staff to resident ratios. Licenses/ certifications were verified by the staffing manager/ Human Resources for current licensed certified staff.	6/16/23

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

Electronically Signed | 05/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060907	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD NORTH BERGEN, NJ 07047

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S 560	Continued From page 1 Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.	S 560	4. DON / Designee to in-service Staffing Coordinator on appropriate staffing levels. Facility has advised open jobs through online recruitment platforms as well as traditional recruitment firms. The facility has conducted job fairs and has contracts with nursing staffing agencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060907	A. BUILDING: _____ B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD NORTH BERGEN, NJ 07047

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S 560	Continued From page 2 (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the 2-week period beginning 3/26/23 to 4/1/23 and ending 4/2/23 to 4/8/23 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements in CNAs to total staff on 2 of 14 day shifts as follows: For the 2 weeks of staffing 3/26/2023 to 4/1/2023 and 4/2/2023 to 4/8/2023) the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: - 3/28/23 had 20 CNAs for 173 residents on the day shift, required 22 CNAs. - 4/2/23 had 17 CNAs for 164 residents on the day shift, required 20 CNAs. On 4/26/23 at 1:14 PM, the facility's Licensed Nursing Home Administrator (LNHA), Director of Nursing, Regional LNHA and Regional Clinical Specialist were informed of this deficient practice. No further information was provided.	S 560		

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
315307 Y1	A. Building B. Wing Y2	7/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD 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 F0584	Correction	ID Prefix F0655	Correction	ID Prefix F0658	Correction
Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	06/16/2023	LSC	06/16/2023	LSC	06/16/2023
ID Prefix F0677	Correction	ID Prefix F0689	Correction	ID Prefix F0695	Correction
Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(i)	Completed
LSC	06/16/2023	LSC	06/16/2023	LSC	06/16/2023
ID Prefix F0725	Correction	ID Prefix F0755	Correction	ID Prefix F0759	Correction
Reg. # 483.35(a)(1)(2)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(f)(1)	Completed
LSC	06/16/2023	LSC	06/16/2023	LSC	06/16/2023
ID Prefix F0836	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.70(a)-(c)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	06/16/2023	LSC	06/16/2023	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	
4/26/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060907 (Y1)	A. Building B. Wing (Y2)	7/3/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD 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 06/16/2023	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
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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	
4/26/2023	☐ 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
	315307	A. BUILDING **01** B. WING _____	**04/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	**7600 RIVER RD** **NORTH BERGEN, NJ 07047**

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K 000	INITIAL COMMENTS The nursing home building construction was stated to be 90's with no current major renovations or noted additions. It is a four story building Type II (222) protected construction and is fully sprinklered. The nursing home is attached to a hospital on the first and second floors through a breezeway approximately 100' long. The facility utilizes a diesel fire pump to support the fire sprinkler system. The 500 KW exterior diesel generator does 100% of the building and has an interior remote shutoff. The building has 2-passenger elevators and one service device. There is a 13-bed vent unit on the fifth floor. The facility has 12-smoke zones. There is supervised smoke detection located in the corridors, spaces open to the corridors and in resident rooms. The generator outside the facility is stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting and life safety components utilized for preservation of life The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 247 certified beds. At the time of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/19/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 the survey the census was 156. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 131 SS=F	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/19/23, in the presence of the[redacted] it was determined that the facility failed to provide two-hour fire resistance-rated elements and assemblies in accordance with the requirements of NFPA 101, 2012 Edition, Section	K 131	1. The door set astragal between the doors on the second-floor breezeway between the hospital, will be fixed. 2. All residents have the potential to be affected by this deficient practice.	6/30/23

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K 131	Continued From page 2 19.1.3.3* between the hospital and the LTC facility. The deficient practice could affect all residents. This deficient practice was evidenced by the following: At 12:39 PM, the Surveyor and US FOIA (b)(6) observed on floor 2, that the set of fire doors between the hospital and the LTC facility were in the closed position. The door set astragal between the doors was observed to be loose with missing screws. The compromised astragal allowed a gap between the doors from 1/2" to 1/4" towards the top of the doors preventing the door set from being smoke/fire resistant. The doors were labeled 90 minutes each. The findings were verified by the US FOIA (b)(6) at the time of the observation. The was informed of the finding at the Life Safety Code exit conference on 4/19/23. NJAC 8:39-31.1(c) NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.1.3.4.	K 131	3. The US FOIA (b)(6) was in-serviced on ensuring astragal is properly installed with no gaps to ensure smoke/fire resistance per regulations. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure the astragal on the 2nd floor breezeway fire doors is installed properly for sufficient smoke/fire resistance as per regulation. Audits will be reviewed through the monthly QAPI process for the next three months.	
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of	K 161		6/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315307	A. BUILDING **01** B. WING _____	**04/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 161	Continued From page 3 stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview on 4/19/23 in the presence of the US FOIA (b)(6)), the facility failed to provide an acceptable construction type and construction standards in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.1.6.1, Table 19.1.6.1, 19.1.6.2. through	K 161	1. Fireproof coating protection will be installed on the exposed areas of the I-beam in the electrical room on the 4th floor, on the exposed areas of the decking and I-beam of the 3rd floor electrical room, and on the exposed areas of the I-beam in the 1st floor transfer switch	

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K 161	Continued From page 4 19.1.6.7, 19.3.1 and 8.6. This deficient practice was evidenced by the following: 1. At 11:22 AM, the surveyor and US FOIA observed in the floor #4 electrical room by resident room 415, that the lower section of the I-beam was exposed due to missing fireproof coating protection. 2. At 12:11 PM, the surveyor and US FOIA observed in the floor #3 electrical room by resident room 315, that the open ceiling exposed the unprotected decking and I-beam due to missing fireproof coating protection. 3. At 12:32 PM, the surveyor and US FOIA observed in the floor #1 transfer switch room that 3-sections of the I-beam were missing fireproof coating protection. The US FOIA confirmed the findings during the above observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/19/23.	K 161	room. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) was in-serviced on ensuring required areas have sufficient fireproof coating protection. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure the 4th floor electrical room, the 3rd floor electrical room and the 1st floor transfer switch room have sufficient fireproof coating protection. Audits will be reviewed through the monthly QAPI process for the next three months.	
K 211 SS=F	NJAC 8:39-31.2(e) Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced	K 211		6/30/23

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K 211	Continued From page 5 by: Based on interviews and documentation review on 04/19/23, in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice was identified for 10 of 10 fire doors documented on the provided facility floor plans and was evidenced by the following: At approximately 9:45 AM, the surveyor asked the US FOIA [redacted] to provide the annual testing requirements for fire door assemblies. The US FOIA [redacted] stated that currently the facility did not document the required annual testing of the fire door's in accordance with NFPA 80 and NFPA 105 Standard for Smoke Doors Assemblies and other Opening Protectives. The US FOIA [redacted] indicated a monthly fire door inspection was logged, but the annual inspection of the fire door components on the log were not specified. The US FOIA (b)(6) was informed of the finding's at the Life Safety Code Exit Conference on 04/19/23. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 and 105: Standard for fire doors assemblies and other opening protectives NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	1. The annual testing requirements of the facility fire door assemblies will be completed and documented. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) [redacted] will be in-serviced on ensuring the annual testing requirements of the fire door assemblies will be documented. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure the fire door assemblies annual testing will be completed and documented appropriately. Audits will be reviewed through the monthly QAPI process for the next three months.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		6/30/23

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	315307	A. BUILDING 01 B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD 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 353	Continued From page 6 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/19/23 in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to maintain the sprinkler system, by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. During a building tour from 9:30 AM, to 12:25 PM, the Surveyor and [redacted] observed drop ceiling tiles missing, not in place and holes in the ceiling tiles due to oversized tile cuts around the fire sprinkler heads in the following areas of the facility: Resident room 509 bathroom fire sprinkler head missing the escutcheon plate and the ceiling was	K 353	1. Room [redacted]'s bathroom fire sprinkler head will be lowered to give enough clearance around the sprinkler head and the escutcheon plate will be replaced. The [redacted] floor oxygen storage room's fire sprinkler head will be lowered to ensure enough clearance around the sprinkler head. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) [redacted] was in-serviced on ensuring there is sufficient space between the ceiling and the sprinkler heads to ensure enough clearance for the sprinkler head to operate optimally and that the escutcheon plates be in place on	

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	315307	A. BUILDING 01 B. WING _____	04/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD NORTH BERGEN, NJ 07047

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K 353	Continued From page 7 set to low, not giving enough clearance around the sprinkler head. Floor 4 oxygen storage room was observed to have 1 fire sprinkler head obstructed by a ceiling that was set to low, not giving enough clearance around the sprinkler head. Floor 1 transfer switch cage area, 2' x 4' ceiling tile not in place along with openings in the conduit running into the ceiling. The drop ceiling tiles had oversized cuts, allowing smoke and fire into the void above the ceiling. Floor 1 laundry washing machine room was observed to have, 1 fire sprinkler head full of lint, 1 fire sprinkler head with green oxidation and 1 fire sprinkler head with a missing escutcheon plate. Floor 1 elevator room was observed to have approximately 11 areas of ceiling penetrations, filled with an orange fire stop foam. The surveyor asked the US FOIA for the MSDS for the fire stop foam used. The US FOIA provided the fire stop can used in the elevator room. The fire stop can indicated "Fire and Draft Sealant Type V residential" for wood combustible framing. The US FOIA in an interview confirmed the above observations. The US FOIA (b)(6) was informed of the findings at the Life Safety Code Exit Conference on 4/19/23. NJAC 8:39-31.2(e)	K 353	fire sprinkler heads. 4. Maintenance director / designee will conduct a monthly audit x 3 months to ensure there is sufficient clearance for the fire sprinkler heads in room 509□s bathroom and the 4th floor oxygen room and that their escutcheon plates are in place. Audits will be reviewed through the monthly QAPI process for the next three months. 1. The identified 1st floor transfer switch cage area ceiling tiles were replaced to ensure smoke and fire cannot escape into the void in the ceiling. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) was in-serviced on ensuring oversized cuts and / or holes in ceiling tiles are repaired to ensure smoke and fire do not penetrate the ceiling. 4. Maintenance director / designee will conduct a monthly audit x 3 months to ensure there are no holes in the ceiling tile of the 1st floor transfer switch cage area, where smoke/fire can escape into. Audits will be reviewed through the monthly QAPI process for the next three months. 1. The 1st floor laundry room fire sprinkler heads will be serviced to ensure	

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	315307	A. BUILDING **01** B. WING _____	**04/26/2023**

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K 353	Continued From page 8	K 353	no lint and green oxidation are on them and that the escutcheon plates are in place. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) was in-serviced on ensuring that fire sprinkler heads are free from lint and oxidation and the escutcheon plates are properly affixed. 4. Maintenance director / designee will conduct a monthly audit x 3 months to ensure the 1st floor laundry room fire heads remain free from lint and green oxidation and that the escutcheon plate remains in place. Audits will be reviewed through the monthly QAPI process for the next three months. 1. Proper commercially rated fire stop foam was used to fill the penetrations in the 1st floor elevator room. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) was in-serviced on ensuring that sealant used is commercially fire rated per regulation. 4. Maintenance director / designee will conduct a monthly audit x 3 months to ensure penetrations in the 1st floor elevator room ceiling will remain sealed with commercially fire rated sealant per	

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K 353	Continued From page 9	K 353	regulation.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 4/19/23, in the presence of the US FOIA (b)(6) [redacted], it was determined that the facility failed to ensure that (2) two portable commercial air conditioners were installed in accordance with the manufacturer's specifications, and in accordance with the National Fire Protection Association (NFPA) 90 A. This deficient practice was evidenced by the following: At 10:51 AM,, during a tour of the 1st floor utility wing of the building, the surveyor with the US FOIA [redacted] observed (2) two portable commercial air conditioner units in the laundry room. The AC units were observed to have approximately 6" flex vents each installed into the drop ceiling. The surveyor interviewed the US FOIA [redacted] at the time of the observation's, where he stated that the flex vents were installed into the drop ceiling void only, The flex vents installed into the drop ceiling tile will exhaust high moisture content into the void above the drop ceiling and can cause mold or in	K 521	1. The 2 flex vents for the portable commercial air conditioner units located in the 1st floor utility room area will be fixed to properly vent from the building to ensure they will not exhaust high moisture content into the void of the drop ceiling and cause mold or water damage. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) [redacted] was in-serviced on ensuring that portable commercial air conditioner units properly vent to the outside of the building. 4. Maintenance director / designee will conduct a monthly audit x 3 months to ensure the 2 portable air conditioner units in the 1st floor utility room area are venting properly to the outside of the building. Audits will be reviewed through	6/30/23

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K 521	Continued From page 10 extreme cases water damage. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/19/23. NFPA 90 A Standard for the installation of ventilating systems NFPA 101-2012 -19.5.2.1 section 9.2.1 and 9.2.2 NJAC 8:39-31.2(e)	K 521	the monthly QAPI process for the next three months.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and	K 918		6/30/23

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K 918	Continued From page 11 readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documents on 4/19/23, in the presence of the US FOIA (b)(6) it was determined that the facility failed to certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems. This deficient practice was identified for 1 of 1 generator logs provided by the US FOIA and the evidence was as follows: At 10:25 AM, a review of the generator records for the previous twelve (12) months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the US FOIA (b)(6) was performing monthly generator load testing, but did not indicate the required transfer times on the provided log dates: 3/25/23, 2/25/23, 1/28/23, 12/31/22, 11/26/22, 10/29/22, 9/24/22, 8/27/22, 7/31/22, 6/25/22, 5/29/22 and 4/30/22. An interview was conducted with the US FOIA during document review and he stated that currently the transfer time was not provided on the current document. He stated that the current document needed to be updated and required a separate column for identifying monthly transfer times.	K 918	1. The generator record log will be updated to include documented certification that the generator would start and transfer power to the building within 10 seconds. 2. All residents have the potential to be affected by this deficient practice. 3. US FOIA (b)(6) will be in-serviced on the need to document certification that the generator would start and transfer power to the building within 10 seconds. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure documented certification that the generator is starting and transferring power to the building within 10 seconds. Audits will be reviewed through the monthly QAPI process for the next three months.	

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K 918	Continued From page 12 The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/19/23. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1	K 918		
K 921 SS=F	Standard for Emergency and Standby Power Systems Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in	K 921		6/30/23

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K 921	Continued From page 13 accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and documentation review on 4/19/23, in the presence of the [US FOIA (b)(6)]), it was determined that the facility failed to ensure that PCREE (patient care-related electrical equipment) were maintained in accordance with NFPA 99-testing and maintenance requirements PCREE as per NFPA 99-99:10.5.3 The deficient practice was evidenced for (5) five of (5) five PCREE area observations and was evidenced by the following: From 09:00 AM, to 1:15 PM, the surveyor and [US FOIA (b)(6)]) observed patient lift-care equipment (hoyer-lift) that were being charged outside resident rooms in the exit/egress corridor's in the following areas of the facility: Floor-4 outside resident room 402 Floor-4 outside resident room 412 Floor-3 outside resident room 318 Floor-2 outside resident room 216 Floor-1 outside multi-purpose room The [US FOIA] in an interview confirmed the equipment charging contained Lithium-ion batteries and charging the patient lift equipment in the exit/egress corridor was a common practice throughout the facility. The facility did not provide policies and	K 921	1. The maintenance department will install chargers for the patient lift-care equipment (hoyer lift) in dedicated rooms on floor 1-4. 2. All residents have the potential to be affected by this deficient practice. 3. [US FOIA (b)(6)] was in-serviced on ensuring patient lift-care equipment batteries are being charged in dedicated rooms on the units and not in the hallway outside patient rooms. Staff will be in-serviced on ensuring patient lift-care equipment batteries are being charged in dedicated rooms on the units and not in the hallway outside patient rooms. 4. Maintenance director / designee will conduct weekly audits x 3 months to ensure patient lift-care equipment are being charged in dedicated rooms and not in the hallway outside patient rooms. Audits will be reviewed through the monthly QAPI process for the next three months.	

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K 921	Continued From page 14 procedures for inspection, testing and maintenance for patient care related electrical equipment, and inventory form was not available for review. The US FOIA (b)(6) was informed of the findings at the Life Safety Code exit conference on 4/19/23. NJAC 8:39-31.2(e) NFPA 99-99:10.5.3	K 921		

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
315307 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/3/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HARBORAGE LLC	7600 RIVER RD 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0131	06/30/2023	LSC K0161	06/30/2023	LSC K0211	06/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	06/30/2023	LSC K0521	06/30/2023	LSC K0918	06/30/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0921	06/30/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
4/26/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO