STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315377	A. BUILDING ______ B. WING ______	C 03/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTORS FUND HOME, THE	**175 WEST HUDSON AVE ENGLEWOOD, NJ 07631**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint #: NJ00152257 Census: 85 Sample Size: 3 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 609	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		4/7/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 04/07/2022

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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	315377	A. BUILDING ______ B. WING ______	C 03/24/2022

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ACTORS FUND HOME, THE	175 WEST HUDSON AVE ENGLEWOOD, NJ 07631

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F 609	Continued From page 1 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00152257 Based on interviews and record review, as well as review of pertinent facility documents on 3/10/22 and 3/24/22, it was determined that the facility staff failed to report an allegation of abuse to the Administrator of the facility and follow their policy on "Prohibition of Resident Abuse and Neglect" for 1 of 3 residents (Resident #2). This deficient practice is evidenced by the following: 1. According to the "FACE SHEET (FS)" form, Resident #2 was admitted to the facility on 9/28/20, and discharged on 8/27/21 with diagnosis that included but was not limited to: Anxiety Disorder. The Minimum Data Set (MDS), an assessment tool dated 7/20/21, showed that Resident #2's cognition was severely impaired and required extensive assistance from staff in Activities of Daily Living (ADL). Reviewed of the written complaint received by the Social worker (SW) from Resident #2's representative (RR) dated 6/16/21 at 11:25 am, showed that Resident #2 reported to the RR that one of the nurses was verbally abusive and rough towards Resident #2. Reviewed of Resident #2's medical record (MR) and the Incident and Accident log showed no	F 609	The resident # 2 is no longer with the facility and was discharged on 8/27/2021. The resident is no longer here, however to ensure this would not happen to any other resident in the future a mandatory in-service / education was held on 4/1/2022 with all staff to review the facility's complaints & grievance policy. It was emphasized that all complaints need to be reported to the administrator / DON, Director of Social Services. In addition, on 4/8/2022 the Administrator & Director of Nursing held a mandatory in-service for all managers / supervisors to ensure that all complaints are properly reported. In addition the facility reviewed the abuse reporting requirements and the Actors Fund Home Abuse policy. At the time the facility also reviewed any other incidents regarding other residents to make sure it was reported if required to do so. After a review of incident reports, the 24 hour reports it was determine that there were no other incidents that required to be reported. To ensure that this does not happen again the facility will review and monitor all complaints and incident reports and make sure they are properly reported to the	

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	315377	A. BUILDING ______ B. WING ______	C 03/24/2022

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F 609

Continued From page 2

documented evidence that the aforementioned complaint was investigated by the Administrator or the Director of Nursing (DON).

Interviewed with the SW on 3/24/22 from 9:30 am to 12:50 pm, the SW confirmed that she received the aforementioned complaint from the RR, however, the SW could not recall if she reported the aforementioned allegation of staff to resident abuse complaint to the Administrator, the DON, or nursing supervisor.

Interviewed with the Director of Nursing (DON) and Administrator on 3/24/22 at 9:30 am, they stated that the aforementioned allegation of staff to resident abuse was not reported to them by the SW, so this is why the allegation was not investigated and reported to the New Jersey Department Of Health (NJDOH). The DON and Administrator further stated that any allegations of abuse received by the staff must be reported to Administrator or DON immediately so it could be investigated and reported to the NJDOH according to their Abuse policy.

The facility's policy titled "Resident rights policy", dated 11/2016, showed "...You have the right to be free from abuse..."

The facility's policy titled " Prohibition of Resident Abuse and Neglect", dated 4/5/2019", showed "...Reporting ...alleged...abuse...MUST BE REPORTED IMMEDIATELY TO THE EMPLOYEE'S SUPERVISOR. 3. The supervisor must immediately notify the Administrator and/or the Director of Nursing. 4. Abuse allegations...will be immediately reported to the appropriate authorities by the Administrator

F 609

DON / Administrator. Together a conversation will take place to determine if it was a reportable event. If deemed appropriate the administrator / DON will call it into NJ DOH Hotline.

In addition it will notify the NJ Ombudsman's Office, the POA and the residents physician.

The Director of Social services will chair a team to update the facilities customer survey that addresses residents and family member complaints. The survey will be available to all residents by June 1, 2022, we a completion date of July 1, 2022. The results will be used for training and to make any changes. The survey will be completed annually.

The Director of Social Services, DON & Administrator will review complaints on a monthly basis.

To ensure compliance the Quality Assurance Committee will monitor and review all complaints that are mad on a quarterly basis and make sure that they were reported as necessary. The quality assurance committee will also review the results of the satisfaction survey.

This will be done for the next 12 months.

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	315377	A. BUILDING ______ B. WING ______	C 03/24/2022

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ACTORS FUND HOME, THE	**175 WEST HUDSON AVE** **ENGLEWOOD, NJ 07631**

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F 609	Continued From page 3 and/or Director of Nursing including but not limited to, Local law enforcement agencies, NJDOH, and NJ Ombudsman in compliance with regulatory requirement. 5. Reports must be submitted in writing, which may include incident report, employee statement, grievance/concern form, or other written documentation..." The facility's policy titled " Resident Abuse Incidents", dated 4/5/2019, showed "...To ensure our residents live in such an environment, the [facility] has developed and operationalized policies and procedures that prohibit abuse, neglect...1...The Administrator will notify the Department of Health and the New Jersey Ombudsman's Office within 24 hours of the complaints...2...within 24 hours of the complaint, will begin a full investigation...4. The Employee Supervisor or HR manager obtain signed statements from the employee in question and other staff/witnesses. 5. Complete Accident/Incident reports and Investigation statements must be submitted to the Abuse Coordinator within 72 hours of complaint. 7. Within 72 hours of the complaint, a final decision is made by the Administrator based on the investigation and written documentation. The plan of Action and Reportable Event Report will then be completed and faxed to the DOH and the New Jersey Ombudsman's office by the Administrator..." NJAC 8:39-4.1(a) (5) NJAC 8:27.1 (b) NJAC 8:39-9.4(e)(3)(I)	F 609		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315377	A. Building B. Wing	5/2/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ACTORS FUND HOME, THE	175 WEST HUDSON AVE ENGLEWOOD, NJ 07631

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 F0609 Reg. # 483.12(c)(1)(4) LSC	Correction Completed 04/07/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
3/24/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO