STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaints #: NJ156387, NJ166254, and NJ162928. Survey Dates: 02/26/24 through 03/05/24. Survey Census: 59 Sample Size: 22 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F 732		3/15/24

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

Electronically Signed | 03/20/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 1 §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to prominently post daily nurse staffing information readily accessible to residents and visitors of 59 census residents. Findings include: Observations conducted on 02/26/24, 02/27/24, and 02/28/24 in the front lobby area and observations of the areas closest to the East and West Hall nurse's stations revealed the staffing data was not found to be prominently posted. During an interview on 02/27/24 at 9:00 AM, the US FOIA (b)(6) was asked if the nursing data was posted in the lobby area and she stated, "I don't think so ..." and she stated she wasn't familiar	F 732	ELEMENT ONE: CORRECTIVE ACTION: The daily nursing staffing sheet was immediately placed on skilled nursing unit in a prominent visible area. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents that require nursing care have the ability to be affected. ELEMENT THREE: SYSTEMIC CHANGES: Staffing coordinator and Director of Nursing were re-in serviced on where to place the daily staffing sheet. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance, Director of Nursing/designee will audit placement of daily staffing sheet daily x7, weekly x2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 2 with a "staffing form." Observations on 02/28/24, both in the lobby area at 10:30 AM and near the two nurse's stations on the long-term care halls from 11:10 AM through 11:30 AM revealed no staffing data was posted prominently for easy access for residents and visitors to define the number of nursing hours related to the facility census. During an interview on 02/28/24 at 12:40 PM, the US FOIA (b)(6)) was asked about the staffing data and the US FOIA (b) stated she thought it was posted downstairs in the front lobby. During an interview on 02/29/24 at 9:00 AM the US FOIA (b)(6) stated she had spoken with US FOIA (b) and the nurse staffing information would now be located on the wall at the long-term care entrance, near the elevators. The US FOIA (b)(6) was asked for a facility policy related to the posting requirements and she stated " ...there isn't a specific policy for that - we know it's supposed to be posted ..."	F 732	then monthly x2 to ensure proper placement. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 3 to Quality Assurance Performance Improvement team for review and action as necessary.	
F 814 SS=F	NJAC8:39-41.2(a)(b)(c) Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to properly contain trash in a closed dumpster resulting in trash overflowing the dumpster area, spilling onto the ground of 59	F 814	ELEMENT ONE: CORRECTIVE ACTION: The dumpster area was cleaned. ELEMENT TWO: IDENTIFICATION OF	3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD NORTH BERGEN, NJ 07047

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 3 census residents. Findings include: During an observation on 02/26/24 at 9:00 AM, the dumpster area had trash overflowing onto the ground. At 11:10 AM, the dumpster area was observed to have primarily plastic wrappings, cardboard boxes, and pieces of boxes overflowing the dumpster with the lid opened. The US FOIA (b)(6)) stated, "trash will be picked up tomorrow." She said she would take care of the overflow. During an observation on 02/28/24 at 1:00 PM, the dumpster lid was closed, but there was still primarily discarded plastic refuse remaining that could NJ Ex Order 26.4b1 in the area. During an observation on 02/29/24 at 7:30 AM, the dumpster area continued to have plastic wrappings and garbage outside the dumpster and the ground was littered with wet trash. During an interview on 02/29/24 at 9:20 AM, the US FOIA (b)(6) was asked if there was a policy for trash disposal, and she said she didn't think there was a policy. She stated she had spoken with the US FOIA and, " ...trash is picked up twice a week and we know it's required to keep it clean and contained in that area." She stated if there was a policy she would provide one. At 12:00 PM, she stated there was no specific policy, but they (facility) would take care of the trash situation. NJAC 8:39-19.3(c) NJAC 8:39-19.7(a)(b)	F 814	AT RISK RESIDENTS: All residents that require garbage disposal have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: Garbage pick up was increased to three times per week. Director of Housekeeping was in-serviced on monitoring outside dumpster twice daily on scheduled work days to ensure area free of debris. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance Executive Director/designee will audit outside dumpster area to ensure free of debris daily x7, weekly x2 then monthly x2 . Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 3 to Quality Assurance Performance Improvement team for review and action as necessary.	

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
	030901	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD 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 is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	ELEMENT ONE: CORRECTIVE ACTION: There was no negative outcome to the resident on the shifts identified as not meeting the NJ staffing requirements on the following shifts: 07/17/22 on the day shift, 07/18/22 on the day shift, 07/21/22 on the evening shift, 07/23/22 on the day shift, 07/24/22 on the day shift, 07/25/22 on the day shift, 07/29/22 on the day shift, 07/30/22 on the day shift. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents in the facility had the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: Current staffing ratios are within compliance. Staffing ratio requirements reviewed with Nurse	3/15/24

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

Electronically Signed | 03/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030901	A. BUILDING: _____ B. WING _____	C 03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD NORTH BERGEN, NJ 07047

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S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 2 weeks of Complaint staffing from 07/17/2022 to 07/30/2022, the facility was deficient in CNA staffing for residents on 7 of 14 day shifts and deficient in total staff for residents on 1 of 14 evening shifts as follows: -07/17/22 had 5 CNAs for 59 residents on the day shift, required at least 7 CNAs. -07/18/22 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs. -07/21/22 had 5 total staff for 59 residents on the evening shift, required at least 6 total staff. -07/23/22 had 5 CNAs for 58 residents on the day shift, required at least 7 CNAs. -07/24/22 had 5 CNAs for 58 residents on the day shift, required at least 7 CNAs. -07/25/22 had 5 CNAs for 58 residents on the day shift, required at least 7 CNAs. -07/29/22 had 5 CNAs for 58 residents on the day shift, required at least 7 CNAs. -07/30/22 had 5 CNAs for 59 residents on the day shift, required at least 7 CNAs.	S 560	Management to ensure proper staffing ratios continue. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance, DON will audit staffing ratios weekly x4, then monthly x 12. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 12 to Quality Assurance Performance Improvement team for review and action as necessary.	

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)
315525	A. Building B. Wing	5/17/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD 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 F0732 Reg. # 483.35(g)(1)-(4) LSC	Correction Completed 03/15/2024	ID Prefix F0814 Reg. # 483.60(i)(4) LSC	Correction Completed 03/15/2024	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
030901 Y1	Y2	5/17/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD NORTH BERGEN, NJ 07047

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 03/15/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

EVENT ID: 018012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING **01** B. WING _____	**03/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	**3161 KENNEDY BLVD** **NORTH BERGEN, NJ 07047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 03/05/24. The facility was found to be in compliance with 42 CFR 483.73	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 03/05/24 and was found to be in non-compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Harbour View Senior Living Corp is a one-story building that was built in the 1980's. It is composed of Type II protected construction. The facility is divided into four - smoke zones. The generator does approximately 50 % of the building per the Maintenance Director. The current occupied beds are 58 of 60.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure emergency lighting was provided	K 291	ELEMENT ONE: CORRECTIVE ACTION: Emergency light fixture was	3/29/24

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

Electronically Signed | 03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING **01** B. WING _____	**03/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	**3161 KENNEDY BLVD** **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 291	Continued From page 1 at the emergency generator transfer switch in accordance with NFPA 110, Standard for Emergency and Standby Power Systems (2010 Edition) Section 7.3. This deficient practice had the potential to affect all 58 residents who resided at the facility. Findings include: An observation on 03/05/24 at 12:37 PM revealed emergency lighting was not present at the emergency generator transfer switch located in the electrical room. During an interview at the time of the observation, the[redacted] confirmed the emergency lighting was not present. NJAC 8:39-31.2(e) NFPA 99, 110	K 291	ordered immediately and installed on 3/28/24. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have potential to be at risk. ELEMENT THREE: SYSTEMIC CHANGES: [redacted] and staff educated on requirement of a safety light at generator transfer switch. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance,Maintenance director/NHA will audit weekly x2 then monthly x2 to ensure proper placement and function of safety light. Needed corrections will be addressed as they are discovered. Findings to be reported monthly x 3 to Quality Assurance Performance Improvement team for review and action as necessary. * PLEASE SEE ATTACH PICTUREFOR K0291 TRANSFER BOX LIGHT	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system	K 345		3/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING **01** B. WING _____	**03/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	**3161 KENNEDY BLVD** **NORTH BERGEN, NJ 07047**

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K 345	Continued From page 2 acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure sensitivity testing of the smoke detectors were completed every alternate year in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition) Section 14.4.5.3.2. This deficient practice had the potential to affect all 58 residents who resided at the facility. Findings include: A review of the facility's "Inspection and Testing Reports," dated 01/10/24, provided by the US FOIA (b)(6), revealed the report had no reference to a smoke detection sensitivity test. Observations on 03/05/24 from 12:08 PM to 2:30 PM revealed the smoke detectors were in the corridors at the smoke barriers, and other concealed areas throughout the building. During an interview at the time of the observations, the US FOIA (b)(6) confirmed the smoke sensitivity testing was not completed on the smoke detectors. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345	ELEMENT ONE: CORRECTIVE ACTION: Sensitivity testing confirmed completed July 2023 and full report available. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have potential to be at risk. ELEMENT THREE: SYSTEMIC CHANGES: US FOIA (b)(6) and staff educated on requirement of smoke detector sensitivity testing every 2 years and maintain full report copy in document binder. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance,Executive director, NHA or designee will audit completion of required testing every 2 years, Due July 2025, with full report available. Will review required upcoming inspections at QAPI quarterly. * PLEASE SEE THE ADDITIONAL ATTACHMENTS OF SENSITIVITY TEST COMPLETION AND PASSING JULY 2023	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101	K 761		3/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING **01** B. WING _____	**03/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	**3161 KENNEDY BLVD** **NORTH BERGEN, NJ 07047**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 761	Continued From page 3 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observations, documentation review, and interview, the facility failed to ensure the fire doors were inspected annually by an individual who could demonstrate knowledge and understanding of the operating components in accordance with NFPA 101 Life Safety Code (2012 Edition) Section 7.2.1.15. This deficient practice had the potential to affect all 58 residents who resided at the facility. Findings include: A review of the facility's fire safety binder provided by the facility revealed no documented evidence that the facility's fire doors were inspected. Observations of the facility's fire doors on 03/05/24 from 12:08 PM to 2:30 PM revealed the doors lacked the required inspection tags to be placed on the doors after completed inspections. The US FOIA (b)(6) was present at the	K 761	ELEMENT ONE: CORRECTIVE ACTION: Door inspection checklist obtained and inspections initiated immediately and completed 3/27/24 with doors tagged/labeled appropriately. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have potential to be at risk. LEMENT THREE: SYSTEMIC CHANGES: US FOIA (b)(6) and staff educated on the requirement and process of annual door inspections and door tag requirements. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance, Executive director, NHA or designee will audit completion of required Fire Door inspections annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING **01** B. WING _____	**03/05/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 761	Continued From page 4 time of the observations and confirmed the fire doors were not inspected annually. NJAC 8:39-31.2(e) NFPA 80	K 761	Needed corrections will be addressed at time of discovery. Will review required upcoming inspections at QAPI quarterly. * PLEASE SEE ATTACHED FORM FOR DOOR CHECK AND TAG ON DOOR	
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		3/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING **01** B. WING _____	**03/05/2024**

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K 918	Continued From page 5 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 record review and interview, the facility failed to ensure the three-year load bank test was completed on the emergency generator in accordance with NFPA 110 Standard for Emergency and Standby Power Systems (2010 Edition) Section 4.9.1. This deficient practice had the potential to affect all 58 residents who resided at the facility. Findings include: A review of the facility's generator reports dated for the years 2022 and 2023, provided by the facility revealed a three-year load bank test had not been completed for the emergency generator. Testing records prior to 2022 were not available for review. During an interview on 03/05/24 at 11:55 AM the US FOIA (b)(6) confirmed the three-year load bank test had not been completed on the emergency generator. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	ELEMENT ONE: CORRECTIVE ACTION: Three-year load bank test completed and passed 3/21/2024. ELEMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS: All residents have potential to be at risk. ELEMENT THREE: SYSTEMIC CHANGES: US FOIA (b)(6) and staff educated on requirement of the 3-year load bank generator test and report requirement. Load bank test due date added to maintenance flowsheet for continued awareness for any future staff. ELEMENT FOUR: QUALITY ASSURANCE: To maintain and monitor ongoing compliance, Executive director, NHA or designee will audit completion of required testing every 3 years, Due by March 21 2027, with full report available. Needed items will be addressed upon discovery. Will review required upcoming inspections at QAPI quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. BUILDING **01** B. WING _____	**03/05/2024**

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K 918	Continued From page 6	K 918	* PLEASE SEE THE ATTACHED RESULTS AND RECEIPT	

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
315525 Y1	A. Building 01 - ANNEX2 B. Wing Y2	5/17/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOUR VIEW SENIOR LIVING CORP	3161 KENNEDY BLVD 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 K0291	03/29/2024	LSC K0345	03/15/2024	LSC K0761	03/29/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	03/29/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	
3/5/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO