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 08/01/2023

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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F 000	INITIAL COMMENTS Complaint #: NJ00165860 Census : 60 Sample Size : 4 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 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00165860 Based on observation, interviews, medical record	F 812	Hudson Hills Senior Living, LLC Facility ID 315525 Survey date 8/1/2023	8/2/23

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

Electronically Signed | 08/25/2023

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F 812	Continued From page 1 review, and review of other pertinent facility documents on 7/31/23 and 8/1/23, it was determined that the facility failed to ensure that the staff had checked and documented the temperature daily on the refrigerator located in the West Unit pantry first floor and that staff had labeled and dated the residents' food items for storage in the fridge for 1 of 2 units. The facility also failed to follow its policies titled "Foods Brought by Family/Visitors" and "Food Storage Procedure." This deficient practice is evidenced by the following: During the tour of the first floor, West unit on 7/31/23 at 11:48 a.m, in the presence of the Unit Clerk (UC), the surveyor observed that the refrigerator located on the first-floor west unit pantry did not have temperatures documented on the "REFRIGERATOR TEMPERATURE LOG (RTL)" for the month of 7/2023 from 7/25/23 to 7/30/23. A total of 6 days. In addition, 1 container dated 7/21/23, 1 container of pineapple and 1 container of soup with no labels, and grapes in plastic with no labels. According to the UC, the refrigerator was used to store food items for residents in the West Unit. The surveyor further observed a form was attached to the refrigerator indicating, "ATTENTION ALL VISITORS AND STAFF ALL FOOD OR DRINKS PLACED IN THE FRIDGE MUST BE LABELED WITH NAME AND DATE. ALL ITEMS WILL BE DISCARDED AFTER 3 DAYS. ANY ITEMS NOT LABELED WILL BE DISCARDED. THANKS MANAGEMENT." During an interview with the Director of Nursing (DON) on 7/31/23 at 3:41 p.m., in the presence of	F 812	F812 SS D ELEMENT ONE: CORRECTIVE ACTION On 8/1/2023 all food items in the affected refrigerators were discarded. Temperatures were taken on the affected refrigerators and they were found to be satisfactory. ELMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS All residents have the potential to be affected by this deficient practice. ELEMENT THREE: SYSTEMIC CHANGES: On 8/2/2023 Nursing staff were re-educated on the components of this regulation with an emphasis on monitoring and documenting refrigerator temperatures, labeling food items and dating food items. ELEMENT FOUR: QUALITY ASSURANCE: Administrator / Designee to audit daily x 7, weekly x4,and monthly x 3, resident refrigerators to assure that temperatures are taken and food items are labeled and dated. Needed corrections will be addressed as they are discovered. Results to be reported monthly to QAPI team for review and	

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F 812	Continued From page 2 Licensed Nursing Home Administrator (LNHA) and Regional LNHA (RLNHA), she stated that it was the housekeeping department's job to ensure that the refrigerator was clean daily and foods that were more than 3 days were to be discarded. During an interview with the Director of Environment on 8/1/23 at 9:00 a.m., he stated that the housekeeping department was responsible for deep cleaning the West Unit refrigerator every first and fifteenth of each month. During a second interview on 8/1/23 at 9:33 a.m., the DON stated that it was the Unit Manager's responsibility to check the refrigerator temperature and to make sure that there was resident's food was not expired or to be discarded after 3 days of the label. The DON confirmed that the resident's food items should be labeled and dated. She stated that foods not labeled/dated should be thrown away. During an interview with the Unit Manager (UM) on 8/31/23 at 10:00 a.m., she stated that food items from the community must be labeled with the resident's name and dated prior to storing them in the pantry refrigerator. The UM revealed that she could not tell if the refrigerator had been checked on the aforementioned dates because she was off. A review of the facility's policy titled, Foods Brought by Family/Visitors, reviewed on 5/18/23, included the following: "...5. Containers will be labeled with the resident's name, the item and the 'use by' date. 6. The nursing staff is responsible for discarding perishable foods on or before the 'use by' date. 7. The nursing and/or food service	F 812	revision as necessary. COMPLETION DATE: 8/2/2023	

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F 812	Continued From page 3 staff must discard any foods prepared for the resident that show obvious signs of potential foodborne danger, for example, mold growth, foul odor, past due package expiration dates)..." A review of the facility's policy titled, "[Facility Name] Food Storage Procedure" undated, revealed the following: "...All foods stored in the refrigerator or freezer will be covered, labeled and dated. 6. Refrigerated foods must be stored at or below 40 F [Fahrenheit] unless otherwise specified by law. 7. Functioning of the refrigeration and food temperatures will be monitored at designated intervals and documented according to state-specific requirements..."	F 812		
F 842 SS=D	NJAC 8:39-17.2 (g) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		8/2/23

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F 842	Continued From page 4 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

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F 842	Continued From page 5 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00165860 Based on interviews, medical record review, and review of other pertinent facility documents on 7/31/23 and 8/1/23, it was determined that the facility failed to consistently document in the "Documentation Survey Report" (DSR) *Ex Order 26. 4B1* [redacted] care as being provided to Resident #1, Resident #2, and Resident #3 reviewed for documentation. The facility also failed to follow its policy titled '*Ex Order 26. 4B1* [redacted] and the "Certified Nursing Aide" job description. This deficient practice was identified for 3 of 3 residents and was evidenced by the following: 1. According to the facility Admission Record (AR), Resident #1 was admitted on *Ex Order 26. 4B1* with a diagnosis that included but ware not limited to *Ex Order 26. 4B1* [redacted]. The Minimum Data Set (MDS), an assessment tool, dated *Ex Order 26. 4B1* [redacted], revealed a *Ex Order 26. 4B1* [redacted] of *Ex Ord*, which indicated the Resident's cognition was *Ex Order 26. 4B1* and	F 842	Hudson Hills Senior Living, LLC Facility ID 315525 Survey date 8/1/2023 F842 SS_D ELEMENT ONE: CORRECTIVE ACTION Confirmed with CNA□s that ADL□s were performed during the cited shifts. On 8/2/2023 Deficient CNA□s were re-educated on the components of this regulation with an emphasis on documentation of ADL□s. ELMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS An audit was performed on 8/2/2023 by DON on all resident ADL□s to identify any gaps in the ADL documentation and address accordingly. ELEMENT THREE: SYSTEMIC CHANGES:	

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F 842	Continued From page 6 the Resident needed assistance with Ex Order 26. 4B1 [redacted] including toileting, eating, and bed mobility. A Care Plan (CP), initiated on [redacted] and revised on [redacted], included that the Resident was totally dependent on staff for all [redacted] needs. Review of Resident #1's DSR ([redacted] Record) and the progress notes (PN) for the month of 6/2023 and 7/2023 showed no documented evidence that the tasks were completed for eating, bed mobility, and toileting were provided and/or the Resident refused care on the following dates and shifts: On the 7:00 a.m. - 3:00 p.m. shift on 6/2/23 to 6/4/23, 6/6/23, 6/9/23, 6/13/23, 6/14/23, 6/17/23, 6/19/23, 6/20/23, 6/22/23, 6/23/23, 6/25/23, 7/1/23 to 7/4/23, 7/6/23, 7/7/23, 7/10/23 to 7/12/23, 7/14/23 to 7/18/23, 7/20/23, 7/21/23, 7/24/23, 7/26/23, and 7/28/23 to 7/30/23. On the 3:00 p.m. - 11:00 p.m. shift on 6/8/23 to 6/11/23, 6/15/23 to 6/24/23, 7/1/23 to 7/5/23, 7/9/23 to 7/19/23, 7/21/23 to 7/23/23, and 7/25/23 to 7/30/23. On the 11:00 p.m. -7:00 a.m. shift on 6/4/23, 6/13/23, 6/18/23, 6/21/23 to 6/23/23, 6/27/23, 7/14/23, 7/16/23, 7/17/23, and 7/30/23, except for eating. 2. According to the facility AR, Resident #2 was admitted on Ex Order 26. 4B1 with diagnoses that included but were not limited to Ex Order 26. 4B1 [redacted]. The MDS, dated Ex Order 26. 4B1, revealed a Ex Order 26. 4 of Ex Or	F 842	On 8/2/2023 CNA□s were re-educated on the components of this regulation with an emphasis on documentation of ADL□s. DON will monitor Point of Care (POC) dashboard at random times to assure ADL□s are being documented. ELEMENT FOUR: QUALITY ASSURANCE: Director of Nursing / Designee to audit daily x 7, weekly x4, and monthly x 3, resident ADL□s to assure that they are being documented. Needed corrections will be addressed as they are discovered. Results to be reported monthly to QAPI team for review and revision as necessary. COMPLETION DATE : 8/2/2023	

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F 842	Continued From page 7 indicating that the Resident's cognition was Ex Order 26. 4B1 and needed assistance with Ex Order 26. 4B1. The CP initiated on NJ Exec. Order 26:4 included that Resident #2 had an Ex Order 26. 4B1 Ex Order 26. 4B1. A review of Resident #2's DSR and PN for the month of 7/2023 had no documented evidence that the Ex Order 26. 4B1 tasks were completed and/or the Resident refused to care for toileting, bed mobility, and eating on the following dates and shifts: On the 7:00 a.m. - 3:00 p.m. shift on 7/11/23, 7/12/23, 7/14/23 to 7/18/23, 7/20/23, 7/21/23, 7/24/23, 7/26/23, and 7/30/23. On the 3:00 p.m. - 11:00 p.m. shift on 7/11/23 to 7/19/23, 7/21/23, 7/23/23 to 7/25/23, and 7/27/23 to 7/30/23. On the 11:00 p.m. - 7:00 a.m. shift on 7/14/23, 7/16/23, 7/17/23, 7/20/23, and 7/30/23, except for eating. 3. According to the facility AR, Resident #3 was admitted on Ex Order 26. 4B1 with a diagnosis that included but was not limited to: Ex Order 26. 4B1. The MDS, dated Ex Order 26. 4B1, revealed a Ex Order 26. 4B1 of Ex Order 26. 4B1, which indicated that the Resident's cognition was Ex Order 26. 4B1 and needed assistance with Ex Order 26. 4B1. The CP initiated on Ex Order 26. 4B1 and revised on 5/24/23 included that Resident # was Ex Order 26. 4B1 and required maximum assistance with dining.	F 842		

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F 842	Continued From page 8 A review of Resident #2's DSR and PN for the month of 6/2023 and 7/2023 showed no documented evidence that the tasks were completed, and care was provided and/or the Resident refused care for bed mobility, eating, and toileting on the following dates and shifts: On the 7:00 a.m. - 3:00 p.m. shift on 6/3/23, 6/5/23, 6/7/23, 6/19/23, 7/14/23, 7/15/23, 7/25/23, 7/27/23, and 7/30/23. On the 3:00 p.m. - 11:00 p.m. shift on 6/2/23, 6/17/23, 6/18/23, and 6/30/23. On the 11:00 p.m. - 7:00 a.m. shift on 6/5/23, 6/13/23, 6/18/23, 6/21/23 to 6/23/23, 6/27/23, 7/16/23, 7/17/23, 7/23/23, and 7/30/23. During an interview with the surveyor on 8/1/23 at 1:57 p.m., Certified Nursing Assistant (CNA #1), who took care of Resident #1 during 7:00 a.m. to 3:00 p.m. shift, stated that CNAs are responsible for documenting the [redacted] care provided into the Point of Care (is a mobile-enabled app that runs on wall-mounted kiosks or mobile devices that enables care staff to document *Ex Order 26. 4B1* [redacted] at or near the point of care to help improve accuracy and timeliness of documentation). CNA #1 further stated that he would document even if the care was not provided due to refusal. He explained that the documentation must be completed in the Resident's DSR by the end of each shift to show that the care was provided to the residents. CNA #1 could not explain why there were blanks in the sampled Resident's DSR but stated that it [the DSR] should have been completed [signed]. During an interview with the surveyor on 8/1/23 at 10:00 a.m., the Licensed Practical Nurse (LPN #1) stated that the CNAs were expected to document the [redacted] care provided to the Resident	F 842		

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F 842	Continued From page 9 by the end of the shift in the DSR. She explained that the Unit Managers (UM) were to check the documentation to ensure the DSR was completed at the end of the shift. LPN #1 could not explain why there were blanks in Resident #1's, Resident #2's, and Resident #3's DSR but stated that they should have been completed to show that the care was provided or if the Resident refused care from the CNAs. Review of the job description titled "Certified Nursing Aide (CNA)," indicated under "DOCUMENTS THE FOLLOWING...8. ADL tracker..." Review of a facility policy titled "Activities of Daily Living (ADLs)," dated 7/1/21, reflected "PRACTICE STANDARDS...5. ADL care is documented every shift by the nursing assistant..."	F 842		
F 880 SS=D	NJAC 8:39-35.2(d)(9) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		8/2/23

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F 880	Continued From page 10 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 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.	F 880		

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F 880	Continued From page 11 §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: Complaint #: NJ00165860 Based on observation, interviews, and record review, as well as review of pertinent facility documents on 7/31/23 and 8/1/23, it was determined that the facility failed to ensure infection control practice was implemented for a resident (Resident #3) observed during [redacted]. The facility also failed to follow its policy titled "Handwashing/Hand Hygiene." This deficient practice was identified for 1of 2 residents and was evidenced by the following: According to the CDC, Morbidity, and Mortality Weekly Report (MMWR) "Guideline for Hand Hygiene in Health-Care Settings, dated October 25, 2002, under "Recommendations: 1. Indications for handwashing and hand antisepsis...G. Decontaminate hands after contact with body fluids or excretions, mucous membranes, nonintact skin, and wound dressings if hands are not visibly soiled. H. Decontaminate hands if moving from a contaminated-body site to	F 880	Hudson Hills Senior Living, LLC Facility ID 315525 Survey date 8/1/2023 F880 SS_D ELEMENT ONE: CORRECTIVE ACTION LPN #1 was immediately re-in serviced on infection control including hand washing and infection control during [redacted] care. ELMENT TWO: IDENTIFICATION OF AT RISK RESIDENTS All residents have the potential to be affected. ELEMENT THREE: SYSTEMIC CHANGES: All staff were re-in serviced on infection control including handwashing and Infection control process during wound	

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 08/01/2023

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F 880	Continued From page 12 a clean-body site during patient care, if gloves became visibly soiled with blood or body fluids following a task..." According to the Centers for Disease Control (CDC) and Prevention titled "Hand Hygiene in Healthcare Settings, reviewed on 1/8/21, under "Techniques for Washing Hands with Soap and Water...When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers...Gloves Use When and How to Wear Gloves...Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient...Carefully remove gloves to prevent hand contamination." According to the Admission Record, Resident #3 was initially admitted to the facility on Ex Order 26. 4B1 with diagnoses that included but were not limited to Ex Order 26. 4B1 . The Care Plan (CP) was initiated on Ex Order 26. 4B1 and revised on NJ Exec. Order 26:4B. The CP indicated that Resident #3 was at risk for Ex Order 26. 4B1. The "Associates in Ex Order 26. 4B1 Care Ex Order 26. 4B1 Care Assessment," dated Ex Order 26. 4B1, showed that Resident #3 had a Ex Order 26. 4B1 to the Ex Order 26. 4B1 area measuring Ex Order 26. 4B1 , undermining Ex Order 26. 4B1 at 6 - 12 o'clock.	F 880	care. Competencies completed on handwashing, and Ex Order 26. 4B1 care, including LPN #1. ELEMENT FOUR: QUALITY ASSURANCE: DON/designee will monitor handwashing on 3 staff members daily x7days, weekly x 4 and monthly x4. DON/designee will monitor wound care on all residents with wounds daily x 7, thereafter DON/designee will monitor wound care on 3 residents twice weekly x4 and monthly x4. Needed corrections will be addressed as they are discovered. Results to be reported monthly to QAPI team for review and revision as necessary. COMPLETION DATE : 8/2/2023	

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F 880	Continued From page 13 The Order Summary Report, dated [redacted], showed an order for *Ex Order 26. 4B1* to apply to [redacted] topically one time a day for *Ex Order 26. 4B1*, pack 1/4 of [redacted] with [redacted] with [redacted] gauze and cover. The Treatment Administration Record (TAR) dated [redacted] indicated the aforementioned order, and the treatment was provided by the Licensed Practical Nurse (LPN #1) on 7/31/23. On 7/31/23 at 10:36 a.m. and 10:26 a.m., the surveyor observed LPN #1 performed [redacted] care to Resident #3. LPN #1 walked into the Resident's room with treatment supplies in his hand and placed them on top of the Resident's bedside table. LPN #1 donned clean gloves, grabbed the gauze in a cup with *Ex Order 26. 4B1*, and cleaned the Resident's [redacted] on the [redacted] area. LPN #1, with the same gloves on, packed the [redacted] bed with gauze saturated with [redacted], doffed the dirty gloves, donned a new set of gloves, then covered the *Ex Order 26. 4B1* with 4 x 4 border gauze. LPN #1 removed the gloves, performed hand washing, and rubbed the hands with soap under running water for 12 seconds. LPN #1 then proceeded to perform [redacted] care on the Resident's *Ex Order 26. 4B1*. LPN #1 then washed his hands after completing [redacted] care to the [redacted] for 13 seconds. The facility's Infection Control Preventionist (ICP) was unavailable for an interview during the survey on 7/31/23. The surveyor conducted an interview with LPN #1 on 8/1/23 at 2:45 p.m, he stated that she should have wash hands for 20 seconds and change gloves after cleansing Resident #3's [redacted] area	F 880		

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F 880	Continued From page 14 with *Ex Order 26. 4B1* because it was dirty and to prevent contamination. During the surveyor's interview with the Director of Nursing (DON) on 7/31/23 at 3:41 p.m., with the presence of the Administrator and Regional Administrator, the DON stated that gloves should be removed and washing hands for at least 20 seconds after touching dirty/soiled material, after cleansing the wound, then don clean gloves before applying a new dressing onto the *Ex Order 26. 4B1* to prevent infection. The sample "Hand Hygiene Competency Validation," dated 3/15/23, indicated "...4. Vigorously rubs hands for at least 20 seconds including palms, back of hands, between fingers, and wrists..." Review of LPN #1's "Skills Checklist: Wound Care," dated 3/22/23, indicated, "...Remove current dressing they expose wound remove packing from wound assess warned appearance and appearance of any drainage on the dressing and packing we remove gloves and perform hand hygiene...Prepare supplies for cleaning and dressing wound...don sterile gloves Clean wound working from cleanest to dirtiest..." A review of the facility's inservice for proper hand washing, dated 5/1/23, attached to the inservice was the policy for "Handwashing/Hand Hygiene," indicated "...The facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...4. Employees must wash their hands for at least twenty (20)	F 880		

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F 880	Continued From page 15 seconds using antimicrobial or non-antimicrobial soap and water...Procedure Washing Hands...2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty (20) seconds, then raise hands under a moderate stream of running water at a comfortable temperature..." The facility's policy titled "Handwashing/Hand Hygiene" updated," undated, indicated "Protocol Statement This facility considers hand hygiene the primary means to prevent the spread of infection...2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors...4. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water...Procedure Washing Hands...2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty (20) seconds, then raise hands under a moderate stream of running water at a comfortable temperature..." NJAC 8:39-19.4(a)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315525		8/28/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 08/02/2023	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 08/02/2023	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 08/02/2023
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 8/1/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			