STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING _____ B. WING _____	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

(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 Standard Survey: Census: 129 Sample Size: 31 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation interview and review of facility documentation, it was determined that the facility failed to maintain resident call bells that were accessible and within reach of all residents. This deficient practice occurred for 2 of 26 residents reviewed (Resident #130 and Resident #11). This deficient practice was evidenced by the following:	F 558	1- Inservice done for each staff member caring for resident #130 and #11 on proper call bell use by Assistant Director of Nursing/Inservice Designee. Call bell were placed within reach for residents #130 and #11. Policy on call bell use was reviewed and revised by licensed nursing home administrator. 2- All residents using call bells may be	10/28/22

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

Electronically Signed | 10/14/2022

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F 558	Continued From page 1 1. On 9/1/22 at 11:44 AM, two surveyors observed Resident #130 lying in bed. Resident #130 did not respond to surveyor questions. The resident's call bell (a bell used to summon staff) was observed on the floor behind the resident's bed. On 9/2/22 at 11:03 AM, two surveyors observed Resident #130 lying in bed. The surveyors observed the resident's call bell on the floor behind the resident's bed. The surveyors interviewed Resident #130 at this time. The surveyor asked Resident #130 how they call for staff to come help them. The resident stated that they, "yell". The surveyor asked if there was a button for them to press to call for staff. The resident stated that they cannot find the button. On 9/6/22 at 10:56 AM, two surveyors observed Resident #130 lying in bed. The surveyors observed that the resident's call bell was on the floor behind the bed, not within the resident's reach. On 9/6/22 at 11:06 AM, two surveyors requested that the Certified Nursing Assistant (CNA) for Resident #130 accompany them into the resident's room. The surveyors interviewed the CNA and asked where the resident's call bell should be. The CNA stated that the resident does not like having their call bell near them and that they yell out for help to get staff's attention. On 9/6/22 at 12:26 PM, the surveyor interviewed the Registered Nurse/ Unit Manager (RN/UM). The surveyor stated that Resident #130's call bell was observed on the floor three times on three different days. The surveyor asked the RN/UM where the resident's call bell should be. The	F 558	affected. They may be identified by reviewing the census. 3- Inservice done for all nursing staff on revised call bell use policy. Rounds will be done two times weekly by Director of Nursing/Assistant Director of Nursing/Unit Manager monitor call bell use and proper placement of the call bell. Any issue will be immediately addressed and results reported to the licensed nursing home administrator and Director of Nursing. 4- Audit of 5 residents with call bells will be done monthly by licensed nursing home administrator/Designee to determine proper placement of call bells. Any issue will be immediately addressed and results will be reported to licensed nursing home administrator and Quality Assurance Committee, at least quarterly.	

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F 558	Continued From page 2 RN/UM stated that the call bell should not be on the ground and stated that it should be clipped onto the bed or attached the resident's siderail and within the resident's reach. A review of resident's hybrid medical record revealed the following: The Admission Record indicated that the resident had diagnoses which included but were not limited to Ex Order 26. 4B1 [redacted]. The 7/6/22 quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, revealed that Resident #130 had a Brief Interview for Mental Status (BIMS) score of Ex Order 26. 4B1, which indicated that the resident was Ex Order 26. 4B1. The MDS further reflected that the resident required NJ Exec. Order 26:4.b.1 [redacted]. The fall risk care plan indicated that Resident #130 needed a Ex Order 26. 4B1 [redacted]. 2.) On 9/1/22 at 10:38 AM, two surveyors observed Resident #11 in bed. The resident was non-interviewable and was observed with a Ex Order 26. 4B1 in place attached to a Ex Order 26. 4B1 [redacted] at 6 Ex Order 26. per minute. The call bell was observed to be far from resident's reach.	F 558		

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F 558	Continued From page 3 On 9/2/22 at 11:14 AM, Resident #11 was observed in bed with eyes closed. The call bell was observed to be clipped on to the pull cord close to the wall and was not within resident's reach. On 9/6/22 at 11:16 AM, Resident #11 was observed in bed with eyes open. The surveyor introduced self to the resident. The resident was non-interviewable. The call bell was clipped on to the pull cord close to the wall and was not within resident's reach. The surveyor brought the CNA assigned to Resident #11 inside the room. The CNA confirmed to the surveyor that the resident's call bell was supposed to be placed within resident's reach. The CNA further stated that the call bell was not in the right place and was not within resident's reach. A review of the Admission record for Resident #11 reflected that the resident was admitted to the facility with diagnoses which included but not limited to *Ex Order 26. 4B1* [redacted]. The resident's most recent Annual MDS, an assessment tool used to facilitate the management of care dated 8/1/22, reflected that Resident #11 had a BIMS score of [redacted], indicating *Ex Order 26. 4B1* [redacted]. The MDS further reflected that the resident requires *Ex Order 26. 4B1* [redacted] A review of the care plan titled, "Resident #11 is at *Ex Order 26. 4B1* [redacted]" with an intervention that included, *Ex Order 26. 4B1* [redacted].	F 558		

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F 558	Continued From page 4 On 9/6/22 at 12:46 PM, the surveyors expressed their concerns to the Licensed Nursing Home Administrator (LNHA), Director of Nursing, and RN Regional Coordinator. The surveyor asked if administration would expect that residents would be unable to reach their call bells. The LNHA stated, "of course not". The facility policy, "Call Bell Policy and Procedure" with a revised date of 7/10/22 indicated that, "call bells shall be placed within reach of resident at all times, including but not limited to after care is provided/ repositioning, toileting, bed mobility, and or meals".	F 558		
F 584 SS=D	NJAC 8:39-4.1(a)11; 31.1(b) 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 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	F 584		10/28/22

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F 584	Continued From page 5 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: On 9/6/22 at 11:59 AM, during the lunch meal service in the 5th floor dining room, the surveyor observed that all the meals in the dining room (DR) were served on meal trays and was left on the trays in front of the residents. Further observation revealed that the trays used to serve the resident's meals were observed to be warped. The surveyor also observed the Certified Nursing Assisntant (CNA's) who were providing	F 584	1-The staff assigned to the fifth floor dayroom was inserviced on meal service by the Assistant Director of Nursing/Inservice Designee. They were reminded to remove plates from trays and place them in front of the residents and also to remove the lids from the tables. Staff from the fifth floor dayroom also inserviced on the need to mark any warped trays with an "X", so that when they are returned to dietary, the dietary staff will know to remove those trays from service. Food Service Director ordered new trays to replace those removed from service.	

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F 584	Continued From page 6 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 packet of milk carton, straw papers and other trash in front of the resident. On 9/9/22 at 12:48 PM, the surveyor discussed the above concern to the Administrator, Director of Nursing and Regional Nurse. No further information was provided. N.J.A.C. 8:39-4.1(a)12	F 584	2- All residents eating in the fifth floor dayroom may be affected. They may be identified by reviewing the list of dietary trucks to see which residents are eating in that dayroom. Five residents were reviewed for meal service in the fifth floor dayroom by the Licensed Nursing Home Administrator/designee. New tray use was noted and plates were placed in front of each resident. 3-All nursing staff was inserviced by the Assistant Director of Nursing/Inservice Designee on meal service and were reminded to place plates in front of the residents and remove the lids from the table. All nursing staff were inserviced by Assistant Director of Nursing/Inservice Designee to notify dietary about warped tray by placing an "X" on the tray Dietary staff will be inserviced to remove warped tray from service when an "x" is noted on the tray. 4- Audit of 10 meal trays will be done twice a month by Licensed Nursing Home Administrator/Food Service Director/Designee in the fifth floor dayroom. Any warped trays will be immediately removed. Results will be reported to the Licensed Nursing Home Administrator and Quality Assurance Committee at least quarterly.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after	F 640		10/28/22

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F 640	Continued From page 7 a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.	F 640		

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F 640	Continued From page 8 §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 3 of 26 residents reviewed for resident assessment (Resident #3, Resident #11 and Resident #32). This deficient practice was evidenced by: On 9/6/22 at 12:45 PM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS up to 14 days of the assessment being completed. 1.) Resident #3 was observed to have an Annual MDS with an Assessment Reference Date (ARD) of 7/11/22 and was due to be transmitted no later than 8/15/22. The MDS was not transmitted until 9/8/22. 2.) Resident #11 was observed to have an Annual MDS with an ARD of 8/1/22 and was due to be transmitted no later than 8/29/22. The MDS was	F 640	1- The MDS for resident #3, resident #11 and resident #32 were all exported and submitted on 9/8/22. General inservice on transmitting done by the regional MDS coordinator for the MDS coordinator. Policy on MDS encoding and transmitting was reviewed by the LNHA/Designee. 2- All residents may be affected. They may be identified by reviewing their MDS. A total of ten MDS's for the current month were reviewed by the Director of Nursing/Assistant Director of Nursing/Designee and all ten were found to be transmitted on time. 3- Inservice was done by the regional MDS coordinator on MDS encoding and transmitting. The inservice was done for the purpose of preparing the MDS coordinator for transmitting. The training will be for the purpose of having a backup for transmission. The MDS coordinator may only transmit under the supervision of the regional MDS coordinator. At least bi-weekly the MDS validation report will be compared to the MDS master schedule by the Licensed Nursing Home Administrator/Designee to ensure no MDS's were missed. Any issues will be immediately addressed and will be reported to the Licensed Nursing Home	

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F 640	Continued From page 9 not transmitted until 9/8/22. 3.) Resident #32 was observed to have a Quarterly MDS with an ARD of 8/9/22 and was due to be transmitted no later than 9/6/22. The MDS was not transmitted until 9/8/22. On 9/8/22 at 11:10 AM, two surveyors interviewed the MDS Coordinator about the late transmission of Resident #3's Annual Assessment. The MDS Coordinator stated that she did not transmit the Annual Assessment and that it is the responsibility of the Regional MDS Coordinator to transmit the assessments. On 9/8/22 at 1:00 PM, the survey team interviewed the Licensed Nursing Home Administrator (LNHA) about the facility's process for MDS transmission and expressed their concern about the late Annual Assessment. The LNHA confirmed that the Regional MDS Coordinator transmits the facility's MDS assessments but could not speak to why this assessment was not transmitted timely. On 9/9/22 at 10:58 AM, two surveyors interviewed the Regional MDS Coordinator over the phone. The surveyor asked why the Annual MDS was not completed timely. The Regional MDS Coordinator stated, "I don't know how that happened". The surveyor asked when the Annual Assessment should have been completed. The Regional MDS Coordinator stated, "within 14 days of the completion date". According to the latest version of the Center for Medicare/Medicaid Services (CMS) - Resident Assessment Instrument (RAI) 3.0 Manual (updated October 2019) page 2-21 "The Annual	F 640	Administrator/Director of Nursing. 4- Audit monthly of five MDS's will be reviewed by the Licensed Nursing Home Administrator/Director of Nursing to ensure timely transmission. Issues will be immediately addressed and results reported to the Licensed Nursing Home Administrator and Quality Assurance Committee at least quarterly.	

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F 640	Continued From page 10 assessment is a comprehensive assessment for a resident that must be completed on an annual basis". The manual revealed on page 2-16 "An Annual (Comprehensive) Assessment must be completed no later than care plan completion date + 14 days. The also manual reflected on Page 2-20, "The MDS must be transmitted (submitted and accepted into the QIES ASAP system) electronically no later than 14 calendar days after the care plan completion date."	F 640		
F 656 SS=D	NJAC 8:39-11.2 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		10/28/22

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F 656	Continued From page 11 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. 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 comprehensive care plan to meet the resident's medical needs. This deficient practice was observed for 1 of 3 residents reviewed, Resident #103 as evidenced by the following: On 9/01/22 at 10:20 AM, the surveyor observed Resident #103 lying in bed watching TV. The surveyor also observed a *Ex Order 26. 4B1* on the nightstand, labeled with the resident's name. The resident stated, he/she receives Ex Order 26. 4B1 *Ex Order 26. 4B1* . The surveyor reviewed Resident #103's hybrid medical record. The Admission Record reflected that Resident #103 was admitted with diagnoses that included but not limited to Ex Order 26. 4B1	F 656	1-Care plan for resident #103 was reviewed and updated to include use of a Ex Order 26. 4B1 and diagnosis of Ex Order 26. 4B1. Inservice on proper completion of care plan done for nurse who was responsible for care plan of resident #103. Policy on care plans reviewed and revised by the Licensed Nursing Home Administrator/Designee. 2-All residents who require care plans may be affected. They may be identified by reviewing all care plans. Five residents with *Ex Order 26. 4B1* and diagnosis of Ex Order 26. 4B1 were reviewed by the Licensed Nursing Home Administrator/Designee and found to have proper care plans. 3- Inservice for all licensed nursing staff on care planning and including use of	

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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 656	Continued From page 12 Ex Order 26. 4B1 [redacted]. The surveyor reviewed the September 2022 Physician's Order (PO) form, which showed that Resident #103 had a PO for Ex Order 26. 4B1 [redacted] Ex Order 26. 4B1 related to Ex Order 26. 4B1. The surveyor reviewed Resident #103's Interdisciplinary Care Plans, which showed that the facility did not develop a care plan that included the use of a Ex Order 26. 4B1 [redacted]. On Ex Order 26. 4B1 at 10:00 AM, the surveyor interviewed the Director of Nursing (DON). The DON stated, anyone who has a Ex Order 26. 4B1 diagnosis like Ex Order 26. 4B1 and/or is receiving a Ex Order 26. 4B1 like a Ex Order 26. 4B1, should have that addressed in their care plan. The DON was unable to explain why Resident #103 does not have a care plan addressing this. The surveyor reviewed policy titled, "Optima Care Harbor View Comprehensive Care Plans Policy & Procedures", revised on 1/5/22. The policy reflected, "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical and functional needs is developed and implemented for each resident." "Policy and Interpretation and Implementation: 8. The comprehensive, person-centered care plan will: g. Incorporate identified problems areas; h. Incorporate risk factors associated with identified problems; k. Reflect treatment goals, timetables, and objectives in measurable outcomes;	F 656	Ex Order 26. 4B1 and diagnosis of Ex Order 26. 4B1 Ex Order 26. 4B1. Review of all residents with Ex Order 26. 4B1 and NJ Exec. Order 26:4.b.1 orders to ensure care plans done for those items done by Director of Nursing/Assistant Director of Nursing. 4- Audit of ten residents with orders for NJ Exec. Order 26:4.b.1 and Ex Order 26. 4B1 was done monthly to ensure that care plan is completed for NJ Exec. Order 26 4.b.1 and Ex Order 26. 4B1. Any issues will be immediately addressed and results will be reported to the Licensed Nursing Home Administrator and Quality Assurance committee at least quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING _____ B. WING _____	09/19/2022

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F 656	Continued From page 13 10. Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process." The surveyor reviewed an additional policy titled, "Administering Medication through a Small Volume (Handheld) Nebulizer", approved on 3/20/22. The policy reflected, "Policy statement: The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway." "Policy Interpretation and Implementation: 1. Review the resident's care plan, current orders, and diagnoses to determine resident needs. 2. If the resident suffers from *Ex Order 26. 4B1* [redacted] refer to the *Ex Order 26. 4B1* [redacted], Clinical Protocol in addition to this procedure." The DON was unable to provide the surveyor with any COPD Clinical Protocol information. NJAC 8:39- 11.2(g)	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		10/28/22

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F 657	Continued From page 14 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to review and revise a care plan to reflect changes to a resident's nutritional care for 1 of 3 residents (Resident # 58) reviewed. The deficient practice was evidenced by the following: On 9/1/22 at 10:10 AM, the surveyor observed Resident #58 lying in the bed and observed *Ex Order 26. 4B1* running at *Ex Order 26. 4B1*. The resident was pleasant during the interview process. A review of the Admission Record for Resident #58 revealed that he/she was initially admitted with diagnoses that included but not limited to: *Ex Order 26. 4B1*	F 657	1- NJ Exec. Order 26:4.b.1 plan was developed, reviewed, and revised for resident #58 by the dietician. Inservice was done for staff responsible for the NJ Exec. Order 26:4.b.1 plan for resident #58. Policy on comprehensive care plan policy and procedure was reviewed and revised by Licensed Nursing Home Administrator/Designee. 2-All residents receiving NJ Exec. Order 26:4.b. may be affected. They may be identified by reviewing the physicians orders. Three residents receiving NJ Exec. Order 26:4.b.1 were reviewed and were noted to have proper care plans. 3- All staff involved in completed care plans were inserviced on proper completion of care plans by the Assistant Director of Nursing/Inservice Designee. Any issues will be immediately addressed.	

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F 657	Continued From page 15 Ex Order 26. 4B1 [redacted] A review of an Annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 6/7/22, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated Ex Order 26. 4B1 [redacted]. The MDS further indicated that the resident has a Ex Order 26. 4B1 which was the sole source of nutrition and hydration delivery. A review of the Order Summary Reports reflected the following Ex Order 26. 4B1 which provide the residents NJ Exec. Order 26:4.b.1 An order for Ex Order 26. 4B1 to run at Ex Order 26. 4B1 via Ex Order 26. 4B1 dated Ex Order 26. 4B1. Total volume to be infused: Ex Order 26. 4B1. Up at 17:00 and down when total volume is Ex Order 26. 4B1, remember to set specific hang time below AND every shift Check and ensure accurate rate and NJ Exec. Order 26:4.b. An order for Ex Order 26. 4B1 via Ex Order 26. 4B1 with Ex Order [redacted] Ex Order 26. 4B1 dated Ex Order 26. 4B1. Total volume of NJ Exec. Orde = Ex Order 26. 4B1. On 9/1/22 at 12:30 PM, the surveyor reviewed Resident #58 care plan dated 6/7-6/14/22 for, Ex Order 26. 4B1 status, Ex Order 26. 4B1 to meet NJ Exec. Order 26:4.b.1. Under the intervention portion of that care plan states Ex Order 26. 4B1 [redacted] On 9/12/22 at 9:40 AM, the surveyor interviewed Registered Dietitian (RD#1). RD#1 acknowledged, he/she is responsible for updating the resident's care plans for Ex Order 26. 4B1 and	F 657	All residents with Ex Order 26. 4B1 NJ Exec. Order 26:4.b orders were reviewed for proper care plans. Any issues were immediately addressed and results reported to the Licensed Nursing Home Administrator. 4- An audit of five residents with Ex Order 26. 4B1 NJ Exec. Order 26:4.b orders will be done monthly by the Licensed Nursing Home Administrator/Designee to ensure proper completion of the care plans. Any issues were immediately addressed and results reported to the Licensed Nursing Home Administrator and Quality Assurance committee at least quarterly.	

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F 657	Continued From page 16 anything dietary related, but was unable to state how the Resident #58 care plan was not updated with the change to the *Ex Order 26. 4B1*. The surveyor reviewed policy titled, "Optima Care Harbor View Comprehensive Care Plans Policy & Procedures", revised on 1/5/22. The policy reflected, "Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical and functional needs is developed and implemented for each resident." "Policy and Interpretation and Implementation: 13. "Assessments of residents are ongoing and care plans are revised as information about the residents and residents' condition change." 14. "The Interdisciplinary Team must review and update the care plan." A review of the job description for the Dietitian under Responsibilities/Accountabilities states: 4. "Ensures appropriate documentation of nutritional assessment to the MDS and recommended intervention in the resident chart and/or care plan; reviews the documentation of others regarding nutritional concerns and responds appropriately." 8. "Review resident care plans ..." NJAC 8:39-27.1(a)	F 657		
F 658 SS=E	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.	F 658		10/28/22

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F 658	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow a Professional Standards of Practice by a.) not following a Physician's Order (PO) on application of Ex Order 26. 4B1 to maintain Ex Order 26. 4B1 for 1 of 4 residents reviewed with Ex Order 26. 4B1, Resident #71, b.) failed to label and date an Ex Order 26. 4B1 for 1 of 2 residents reviewed for Ex Order 26. 4B1, Resident # 58, c.) failed to assess a Ex Order 26. 4B1 for 1 of 5 residents reviewed for NJ Exec. Order 26:4.b.1 which did not contribute to Ex Order 26. 4B1, Resident # 124 and, d.) Failed to have a valid physician's order and accurately document the administration of a NJ Exec. Order 26:4.b.1, Resident #61 and Resident #24. 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 registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." This deficient practice was evidenced by the following: a.) On 9/6/22 at 11:14 AM, the surveyor observed Resident #71 inside the room, lying in bed with eyes open. The surveyor further observed Ex Order 26.	F 658	1- (a) Inservice done on placing NJ Exec. Order 26:4.b.1 for staff caring for resident #71. -order reviewed & revised by Director of Nursing/Assistant Director of Nursing. -policy on NJ Exec. Order 26:4.b.1 reviewed & revised by Licensed Nursing Home Administrator/Designee. (b)Inservice was done for staff member responsible for labeling Ex Order 26. 4B1 for resident #58. -policy on Ex Order 26. 4B1 reviewed & revised by Licensed Nursing Home Administrator/Designee. Employee responsible for labeling of the Ex Order 26. 4B1 was counseled on failing to label the Ex Order 26. 4B1. (c) Dietician was inserviced on need for a NJ Exec. Order 26:4.b.1 note for resident #124. That Ex Order 26. 4B1 note was completed as a late entry. -policy on nursing & dietary policy & procedure was reviewed & revised by Licensed Nursing Home Administrator/Designee. (d)Inservice was done for nurse responsible for giving Ex Order 26. 4B1. on 7/2022 on obtaining an order for the medication. Inservice was done by Director of Nursing/Assistant Director of Nursing, nurse was also counseled. (e) Inservice was done for nurses who were responsible for for resident #24 on accurate documentation of administration of Ex Order 26. 4B1 Policy on medication documentation was reviewed and revised by Licensed Nursing	

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F 658	Continued From page 18 Ex Order 2 applied to NJ Exec. Order 26 4.b.1 of the resident. Resident #71 stated to the surveyor that they wear Ex Order 26. 4B1 all day. On 9/7/22 at 11:52 AM, the surveyor observed Resident #71 in bed with eyes closed. The surveyor observed Ex Order 26. 4B1 applied to NJ Exec. Ord NJ Exec. Order 26 of the resident. A review of the Admission record for the Resident #71 reflected that the resident was admitted to the facility with diagnoses which included but not limited to Ex Order 26. 4B1 . The resident's most recent Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 6/30/22, reflected that Resident #71 had a Brief Interview for Mental Status (BIMS) score of Ex Ord, indicating Ex Order 26. 4B1 . A review of the September 2022 Treatment Administration Record showed a PO dated 8/25/22 for Ex Order 26. 4B1 On 9/8/22 at 10:50 AM, the surveyor interviewed the registered Nurse (RN # 1) assigned to Resident #71 who stated that Ex Order 26. 4B1 were applied in the day time after morning care and would only be removed during care to check Ex Order 26. 4B1. The surveyor interviewed the 7-3 Certified Nursing Assistant (CNA # 1) assigned to the resident who stated that when she reported for her shift in the morning, both the Ex Order 26. 4B1 were applied to the resident already. The RN acknowledged to the surveyor that the Ex Order 26. 4B1 were applied at a wrong time and was not according to the physician's order.	F 658	Home Administrator. 2- All residents receiving medication may be affected. They may be identified by reviewing POS & MARS. 3- All licensed nurses were inserviced on placing Ex Order 26. 4B1, labeling Ex Order 26. 4B1 and administering controlled drugs. A review of all residents control drug forms was also done and any results were reported to the Director of Nursing/Licensed Nursing Home Administrator. 4- Five Ex Order 26. 4B1 were audited monthly by Licensed Nursing Home Administrator/Designee to ensure Ex Order 26. 4B1 note was completed. Results will be reported to the Administrator and quality assurance committee at least monthly. Any issues immediately addressed. Five residents' NJ Exec. Order 26:4.b.1 forms were reviewed per month by the Licensed Nursing Home Administrator/Designee in order to determine matching with MAR's. Results will be reported to the Administrator and quality assurance committee at least monthly. Three residents with Ex Order 26. 4B1 were audited monthly by the Administrator/Designee to ensure proper placement. Results will be reported to the Administrator and quality assurance committee at least monthly. Any issues will be immediately addressed. Five residents with Ex Order 26. 4B1 were reviewed for proper labeling monthly by Administrator/Designee. Any issues will be immediately addressed and results will be reported to the Administrator and	

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F 658	Continued From page 19 On 9/8/22 at 12:47 PM, the surveyor discussed the above concern to the Administrator, Director of Nursing (DON) and the Regional RN # 1. There was no further information provided. b.) On 9/02/22 at 8:20am, the surveyor observed Resident # 58 lying in bed asleep. Resident's *Ex Order 26. 4B1* [redacted] was off and the *Ex Order 26. 4B1* [redacted] was NJ Exec. Order 26:4.b.1 [redacted] Surveyor observed the *Ex Order 26. 4B1* [redacted] was not labeled with any information for the resident. A review of the Admission Record for Resident #58 revealed that he/she was admitted with diagnoses that included but not limited to: *Ex Order 26. 4B1* [redacted]. A review of an Annual MDS, an assessment tool used to facilitate the management of care, dated 6/7/22, reflected that the resident had a BIMS score of [redacted] which indicated *Ex Order 26. 4B1* [redacted]. The MDS further indicated that the resident has a *Ex Order 26. 4B1* [redacted] which was the sole source of NJ Exec. Order 26:4.b.1 [redacted]. A review of the Order Summary Reports reflected the following *Ex Order 26. 4B1* [redacted] which provide the residents NJ Exec. Order 26:4.b.1 [redacted]	F 658	quality assurance committee at least monthly. Three residents with NJ Exec. Order 26:4.b.1 [redacted] were audited to be sure they were placed correctly. Audit completed by LNHA/Designee. Five enteral feeding will be reviewed monthly by LNHA/Designee for proper labeling. Any issues will be addressed immediately & reported to the LNHA and QA Committee at least quarterly.	

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F 658	Continued From page 20 An order for *Ex Order 26. 4B1* to run at *Ex Order 26. 4B1* via *Ex Order 26. 4B1* dated *Ex Order 26. 4B1*. Total volume to be infused: *Ex Order 26. 4B1*. Up at 17:00 and down when total volume is *Ex Order 26. 4B1*, remember to set specific hang time below AND every shift Check and ensure accurate rate and feeding. An order for *Ex Order 26. 4B1* via *Ex Order 26. 4B1* with *Ex Order 26. 4B1* dated *Ex Order 26. 4B1*. Total volume of *Ex Order 26. 4B1* = *Ex Order 26. 4B1*. At 8:45am, during an interview with the RN # 2 in residents' room, the RN # 2 acknowledged the *Ex Order 26. 4B1* was not labeled and should contain the resident's name, room number, date, time the *NJ Exec. Order 26:4b* began, *Ex Order 26. 4B1* rate and total volume. The RN # 2 further explained the 3-11 shift nurse was the nurse who hung the *Ex Order 26. 4B1*, and it was their responsibility to label the *Ex Order 26. 4B1*. On 9/07/22 at10:50am, the surveyor interviewed LPN # 1, who acknowledged they *Ex Order 26. 4B1* The LPN # 1 further stated, they know what needs to go onto the *Ex Order 26. 4B1* label and has been in-serviced on that procedure. A review of the facility policy and procedure, *Ex Order 26. 4B1* revised on 3/22/22, reflected as part of their Procedure: 7. *Ex Order 26. 4B1*	F 658		

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c.) On 9/1/22 at 12:00 PM, the surveyor observed Resident # 124 in bed. The resident stated that he/she had Ex Order 26. 4B1 and it was desired as he/she felt good now. Resident # 124 stated that the Ex Order 26. 4B1 happened because he/she had a Ex Order 26. 4B1 and Ex Order 26. 4B1 in the recent past. The resident stated that the food tasted okay, and he/she had a Ex Order 26. 4B1 at most meals.

On 9/2/22 at 10:02 AM, the surveyor interviewed the CNA # 2 assigned to the resident who stated that the resident had been eating better at about Ex Order 26 consumed at most meals and the resident says he/she felt good with his/her Ex Order 26. 4B1.

On 9/2/22 at 10:50 AM, the surveyor interviewed the RN # 3 assigned to the resident who stated that Resident # 124 had been Ex Order 26. 4B1 and had a history of many NJ Exec. Order 26 4.b.1 which may have contributed to the Ex Order 26. 4B1. The resident was Ex Order 26. 4B1 and was currently eating well but the resident said he/she was happy with his/her Ex Order 26. 4B1. The RN # 3 stated that the doctor and interdisciplinary team were following the resident closely with the Ex Order 26. 4B1.

At 12:39 PM, the surveyor observed Resident # 124 in their room served their lunch meal. The resident consumed Ex Order 26. 4B1 of the meal served.

On 9/13/22 at 10:42 AM, the surveyor observed Resident # 124 in their room served their lunch

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meal. The resident again consumed [redacted] of the meal served.

A review of the Admission Record revealed that Resident # 124 had diagnoses which included but were not limited to [redacted].

A review of the quarterly MDS, an assessment tool used to facilitate care management dated 7/11/22, revealed a Brief Interview for Mental Status score of [redacted], which indicated [redacted].

A review of Resident # 124's [redacted] revealed that on 7/13/22, the resident [redacted] and on 8/1/22, the resident weighed [redacted], which indicated a significant [redacted] of [redacted] in one month. The resident did not [redacted] any further [redacted] with a documented [redacted] of [redacted] on 9/1/22.

A review of the resident's progress notes and assessments documented by the interdisciplinary team, which included nursing and the resident's physician, revealed that the resident's meal intake, snack intake and [redacted] status were documented for the [redacted] documented on 8/1/22. Further review of the resident's progress notes and assessments revealed that there was a [redacted] follow up note documented by the Registered Dietitian (RD), which was dated 7/27/22 that revealed that the resident [redacted] and had [redacted] over the last 90 days with recommendations and rationale for this

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Ex Order 26. 4B1. There were no progress notes or assessments done by the RD to assess the Ex Order 26. 4B1 documented on 8/1/22.

On 9/14/22 at 1:00 PM, the surveyor interviewed the RD who was assigned to Resident # 124 and he stated that the resident did have a Ex Order 26. 4B1 documented on 8/1/22 and there was no Ex Order 26. 4B1 note to assess the concern. He stated that there should have been an assessment/progress note written to address the Ex Order 26. 4B1. He also stated that the resident's appetite had improved and the resident was happy with the Ex Order 26. 4B1 plus the resident had not NJ Exec. Ord any further Ex Order 26. 4B1 this month.

On 9/14/22 at 1:42 PM, the surveyor discussed the above concern with the Administrator and DON. There was no further information provided.

The surveyor reviewed the facility's Nursing and Dietary Policy and Procedure, dated 2/24/22, which revealed that Ex Order 26. 4B1

d.) On 9/12/22 while reviewing the 5th floor facility control substance inventory system, the surveyor reviewed the Individual Patient Controlled Substance Administration Record (CSAR) for Resident #61. The CSAR documented a delivery

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from the Provider Pharmacy of #20 Ex Order 26. 4B1 for Resident #61 on 7/16/21. The CSAR also indicated that a dose of Ex Order 26. 4B1 was administered to Resident #61 on 7/3/22.

A review of the Admission Record for the Resident #61 reflected that the resident was admitted to the facility with diagnoses which included but not limited to Ex Order 26. 4B1 . The resident's most recent MDS, dated 6/9/22, reflected that Resident #61 had a BIMS score of , indicating a Ex Order 26. 4B1 .

A review of the Physician Orders (PO) for 7/2022 does not indicate that there was any physician order for Ex Order 26. 4B1 for Resident #61.

A review of the Electronic Medical Administration Record (EMAR) dated 7/2022, does not indicate that there was any entry documenting that the Ex Order 26. 4B1 was administered to Resident #61.

A review of the EMAR dated 7/16/21, documented a physician order for Ex Order 26. 4B1 Ex Order 26. 4B1 for NJ Exec. Ord days. The medication was not documented as administered to Resident #61 and expired on 7/24/21.

A review of the EMAR dated 2/17/22, documented a physician order for Ex Order 26. 4B1 Ex Order 26. 4B1 for Ex Order 26. 4B1 . The medication was documented as administered on 2/17/22 for a NJ Exec. Order 26:4.b.1 of and 2/22/22 for a NJ Exec. Order 26:4.b.1 of . A review of the EMAR dated 3/2022, documented that the order expired on 3/11/22.

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F 658	Continued From page 25 Review of PO from 7/2021 to 7/2022 revealed that there were only two POs for Ex Order 26. 4B1. Review of the Documentation of Medication Administration policy states, "A nurse shall document all medications administered to each resident on the resident's medication administration record (MAR)." On 9/15/22 at 12:15 PM, the surveyor informed the DON and LNHA of this issue and no further information was supplied. e.) On 9/12/22 while reviewing the 5th floor facility control substance inventory system, the surveyor reviewed the CSAR for Resident #24. The CSAR documented that Ex Order 26. 4B1 were delivered from the Provider Pharmacy for Resident #24. The CSAR revealed NJ Exec. Order 26 4.b.1 had been administered to Resident #24 from 8/4/22 to 8/31/22 with #2 documented doses Ex Order 26. 4B1 on 8/29/22 and 9/1/22. A review of the Admission record for the Resident #24 reflected that the resident was admitted to the facility with diagnoses which included but not limited to Ex Order 26. 4B1. The resident's most recent MDS, dated 8/8/22, reflected that Resident #24 had a BIMS score of Ex Ord, indicating a Ex Order 26. 4B1. A review of Resident #24's 8/2022 EMAR, indicated a physician's order for Ex Order 26. 4B1 Ex Order 26. 4B1 for NJ Exec. Order 26:4.b.1 hold if patient Ex Order 26. 4B1 with a start date of 7/15/22, and hold dates of 8/26/22 to 8/29/22. The documented administration times for Ex Order 26. 4B1 was 9:00 AM and 9:00 PM.	F 658		

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F 658	Continued From page 26 Review of the CSAR indicated that *Ex Order 26. 4B1* [redacted] was removed from inventory at 5:00 PM on 8/9/22, 8/10/22, 8/11/22, 8/12/22 and 8/31/22. Review of the documentation for the administration of *Ex Order 26. 4B1* for 8/9/22, 8/10/22, 8/11/22, 8/12/22 and 8/31/22 indicates 9:00 PM. Review of the CSAR indicates that *Ex Order 26. 4B1* [redacted] was removed from inventory on 8/26/22 at 9:00 AM and 9:00 PM.. Review of the 8/2022 EMAR indicates that *Ex Order 26. 4B1* was administered to Resident #24 at 9:00 AM and held at 9:00 PM. Review of the Documentation of Medication Administration policy indicated, "Administration of medication must be documented after (never before) it is given." On 9/2/22 at 2:15 PM, the surveyor met with the DON and Licensed Nursing Home Administrator (LNHA) to discuss findings concerning the discrepancies with documentation involving administration. There was no further information provided during the survey.	F 658		
F 689 SS=D	NJAC 8:39-11.2 (b); 27.1 (a); 29.2(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	F 689		10/28/22

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F 689	Continued From page 27 §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, and record review, it was determined that the facility failed to develop a plan of care and failed to perform a NJ Exec. Order 26:4.b.1 to determine the level of supervision required for 1 of 3 residents reviewed for [redacted], Resident # 22. The deficient practice was evidenced by the following: On 9/1/22 at 11:05 AM, the surveyor spoke with Resident # 22 in the resident's room while the resident sat in a chair. The resident stated they [redacted] at the facility three times a day, at 9 am, 1 pm, and 7 pm. The resident said the [redacted] were locked up in the recreation department as well as the [redacted]. The resident said the staff supervised the [redacted], distributed the [redacted], and lit the [redacted] for the residents. On 9/8/22 at 12:51 PM, the surveyor reviewed the residents hybrid medical record which revealed the following: An Admission Record with diagnoses which included, *Ex Order 26. 4B1* [redacted]. A Significant Change Minimum Data Set Assessment dated 8/5/22 which indicated that the resident scored a *Ex Order 26. 4B1* in the Brief Interview of	F 689	1- [redacted] assessment was completed for resident #22 by nurse. Care plan for [redacted] was also completed for resident #22 by the nurse. Inservice was done on [redacted] assessment and [redacted] care plan for staff member assigned to resident # 22. Policy on [redacted] was reviewed and revised by the Licensed Nursing Home Administrator/Designee. 2- All residents that [redacted] may be affected. They may be identified by reviewing the physicians orders. Five residents identified as [redacted] were reviewed and each were noted to have a completed [redacted] assessment and [redacted] care plan. 3- All residents identified as [redacted] were reviewed for completion of [redacted] assessment and care plan by the Assistant Director of Nursing/Inservice Designee. Inservice was done for all nursing staff on completing [redacted] assessment and [redacted] care plan by Assistant Director of Nursing/Inservice Designee. 4-Five residents identified as [redacted] will be audited monthly by Licensed Nursing Home Administrator/Designee for completing [redacted] assessment and [redacted] care plan. Any issues will be immediately addressed and results will be reported to the Licensed Nursing Home Administrator and Quality Assurance	

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F 689	Continued From page 28 Mental Status exam. This indicated that the resident was Ex Order 26. 4B1. A NJ Exec. Order 26:4.b.1 assessment dated 4/30/22. Question #1 read Ex Order 26. 4B1 the answer was yes. The rest of the assessment was not filled out. Additionally, there was no care plan for NJ Exec. Order 26:4.b.1 The surveyor confirmed with the Registered Nurse (RN) assigned to the resident that a NJ Exec. Order 26:4.b.1 assessment should have been done and that there should have been a care plan for NJ Exec. Order 26:4.b.1. There were no other NJ Exec. Order 26:4.b.1 assessments in the medical record. On 9/8/22 at 1:00 PM, the surveyor spoke with the Administrator and the Director of Nursing (DON) about the resident not being assessed to NJ Exec. Order 26:4 and about there not being a care plan for NJ Exec. Order 26:4.b.1. They confirmed that they should have done a NJ Exec. Order 26:4.b.1 assessment on admission and they should have had a care plan for NJ Exec. Order 26:4.b.1 On 9/9/22 at 10:10 AM, the Administrator and the DON provided the NJ Exec. Order 26:4.b.1 contract from the resident that was signed by the resident on 5/17/22. The Administrator confirmed that there was no NJ Exec. Order 26:4.b.1 completed on admission, or since admission, and there was no care plan for NJ Exec. Order 26:4.b.1. The surveyor observed the resident in the NJ Exec. Order 26:4.b.1 area multiple times throughout the survey. Observed that there was a NJ Exec. Order 26:4.b.1 attendant present while the residents were NJ Exec. Order 26:4.b.1. The NJ Exec. Order 26:4.b.1 area was on the second floor on the outside patio. On 9/9/22 at 11:00 AM, the surveyor reviewed the facility's policy and procedure titled Ex Order 26. 4B1	F 689	Committee.	

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F 689	Continued From page 29 Policy and Procedure" with a revision date of 3/2022. Under "Purpose" number 1. read "Upon admission to the facility all [NJ Exec. Order 26:4.b.1] will be assessed. The resident's level of safety and their level of [NJ Exec. Order 26:4.b.1] privilege will be determined, based on the [NJ Exec. Order 26:4.b.1] assessment." 2. read "Residents will be assessed monthly to ensure that their current level has not changed.	F 689		
F 698 SS=D	NJAC 8:39-11.2 (d) 27.1 (a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to perform [Ex Order 26. 4B1] assessments for 1 of 1 residents reviewed for [Ex Order 26. 4B1] and services, Resident # 127. The deficient practice was evidenced by the following: On 9/1/22 at 11:51 AM, the surveyor observed Resident # 127 laying in bed in the residents room. The resident didn't answer when spoken to. The resident was covered with a blanket. The Registered Nurse (RN) who was assigned to the resident confirmed that the resident went out for [Ex Order 26. 4B1] every [Ex Order 26. 4B1] .	F 698	1- Inservice done for staff caring for resident #127 0n 9/1/22 on [Ex Order 26. 4B1] assessment and documentation. Policy on [Ex Order 26. 4B1] reviewed and revised by the licensed nursing home administrator/Designee to include revised [Ex Order 26. 4B1] communication form with [Ex Order 26. 4B1] assessment. 2- All residents receiving [NJ Exec. Order 26:4.] may be affected. They may be identified by reviewing the physicians orders. Two residents currently receiving [Ex Order 26. 4B1] were reviewed and had proper [Ex Order 26. 4B1] assessments. 3- Sheets titled [Ex Order 26. 4B1] were revised to include a section entitled [Ex Order 26. 4B1] . The	10/28/22

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F 698	Continued From page 30 On 9/8/22 at 10:39 AM the surveyor reviewed the resident's record which revealed the following: An admission record with diagnoses that included *Ex Order 26. 4B1* [redacted]. A current Physician's Order Sheet (POS) with an order that read; *Ex Order 26. 4B1* [redacted] The date of the order was 7/27/22. An Admission Minimum Data Set Assessment dated 8/3/22 that indicated the facility attempted to conduct a brief interview of mental status with the resident NJ Exec. Order 26:4.b.1 [redacted] The staff completed the mental status assessment using NJ Exec. Order 26 4.b.1. It was determined that the resident's cognitive skills for daily decision making were *Ex Order 26. 4B1* . At that time the surveyor reviewed the Ex Order 26. 4B1 communication book which the resident took to Ex Order 26. 4B1. On the sheets titled Ex Order 26. 4B1 [redacted] there was a section where the facility nurse would write an assesment as well as any relevant information prior to sending the resident to Ex Order 26. 4B1 and a section where the Ex Order 26. 4B1 nurse would write information during Ex Order 26. 4B1. There was no section where the nurse would document an assessment of the resident upon return to the facility from Ex Order 26. 4B1. The surveyor reviewed the communication sheet with the RN. The RN confirmed that there was no section for the nurse to document an assessment of the resident upon return from Ex Order 26. 4B1. The RN said she would let the Unit Manager (UM) know.	F 698	section will include NJ Exec. Order 26 4.b.1. Inservice done by Assistant Director of Nursing/Inservice designee for licensed staff on the revised NJ Exec. Order 26:4.b communication form as well as NJ Exec. Order 26:4.b.1 assessment. 4- Monthly audit of completion of three NJ Exec. Order 26:4.b.1 assessments completed by the licensed nursing staff will be done by the licensed nursing home administrator/designee. Any issues found will be immediately resolved and reported to the licensed nursing home administrator and the quality assurance committee at least quarterly.	

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F 698	Continued From page 31 The UM was covering for an absent UM on another floor throughout the survey. The surveyor asked the RN where the nurses documented the assessment of the resident when they returned from [redacted]. The RN said she was not there when the resident returned to the facility from [redacted] because it was on a different shift. The RN said the nursing staff documented their assessment of the resident in the nurses' progress notes. The surveyor reviewed the progress notes for August and September 2022. The August progress notes included ten return notes by the nurse on duty. The resident had thirteen [redacted] visits in August. The nurse did not include an assessment of the resident upon return to the facility from [redacted] in any of the ten nurses progress notes. None of the ten notes included the resident's [redacted] and only one nurses' note included an assessment of the [redacted] access site. The September progress notes included two return notes by the nurse on duty. The resident had three [redacted] visits by that date in September. The nurse did not include an assessment of the resident upon return to the facility from [redacted] in either of the two nurses' progress notes. The two notes did not include the resident's [redacted] upon return to the facility or an assessment of the [redacted] access site. On 9/13/22 at 1:30 PM the surveyor spoke with the Administrator and the Director of Nursing (DON) about the concern with the lack of assessment of the resident upon return from [redacted]. There was no response from the Administrator of the DON, but they stated they would provide the policy for review.	F 698		

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F 698	Continued From page 32 On 9/14/22 at 1:59 PM the surveyor reviewed the facility's Policy and Procedure titled [redacted] revised date 9/5/22. Under [redacted] it read: 1. Upon resident's return from [redacted] the receiving nurse on the unit will check the communication notebook from the [redacted] center for any relevant information/instruction and initial that it was noted. Notify the nursing supervisor for any recommendations that the primary physician should be aware of and follow through. 2. The nurse on the unit will inspect [redacted] for [redacted], and [redacted] every shift & notify MD of any [redacted]. Observe and report indications of [redacted] such as [redacted]. 3. The dietitian will also check the notebook for any relevant information. The [redacted] procedure did not include obtaining the residents [redacted] or address the need for the nurse to document the findings. The surveyor asked the DON if that should have been done upon the resident's return from [redacted]. She said yes it should have been done by the facility nurse upon the resident's return.	F 698		
F 711 SS=E	NJAC 8:39-27.1 (a) Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must-	F 711		10/28/22

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F 711	Continued From page 33 §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the residents' primary physician signed and dated monthly physician orders to ensure that the residents' current medical regimen was appropriate. This deficient practice was observed for 18 of 29 residents (Resident #3, #118, #130, #63, #87, #84, #32, #71, #11, #70, #147, #117, #22, #7, #127, #38, #54, #37) reviewed and occurred over several months. This deficient practice was evidenced by the following: The surveyors reviewed the hybrid medical records (paper and electronic) for the residents listed above which revealed the resident's primary physician had not hand signed the Order Summary Reports (monthly physician's orders) located in the residents' chart. In addition, there were no electronic signatures under the physician's orders for the following residents:	F 711	1- Physician signed and dated the physicians orders for the eighteen residents. -Need for physicians to sign orders monthly was reviewed with each of the physicians. -Medical records clerk was re-inserviced on the need to prepare physicians orders for signatures. The medical records clerk was also instructed to call and remind each physician of the need to sign the monthly orders. 2-All residents requiring physicians orders are at risk. They may be identified by reviewing the monthly physicians orders. 3- An audit of all physician orders was completed to ensure each physician order was signed. 4- An audit of the physician orders will be completed by the Licensed Nursing Home	

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F 711	Continued From page 34 1. Resident #3's hybrid medical records revealed that the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, July 2022, and August 2022. 2. Resident #118's hybrid medical records revealed that the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, July 2022, and August 2022. 3. Resident #130's hybrid medical records revealed that the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, July 2022, and August 2022. 4. Resident #63's hybrid medical records revealed that the resident's physician had not hand-signed or electronically signed the monthly physician orders for June, July, and August 2022. 5. Resident #87's hybrid medical records revealed that the resident's physician had not hand-signed or electronically signed the monthly physician orders for June, July, and August 2022. 6. Resident #84's hybrid medical records revealed that the resident's physician had not hand-signed or electronically signed the monthly physician orders for June, July, and August 2022. 7. Resident #32's hybrid medical records revealed that the resident's physician had not hand-signed or electronically signed the monthly physician orders for June, July, and August 2022.	F 711	Administrator/Designee on a monthly basis. Any issues will be immediately addressed and results will be reported to the Licensed Nursing Home Administrator and the Quality Assurance committee at least quarterly.	

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F 711	Continued From page 35 8.) Resident #71's hybrid medical records revealed that the resident's physician had not hand-signed or electronically signed the monthly physician orders for June, July, and August 2022. 9.) Resident #11's hybrid medical records revealed that the resident's physician had not hand-signed or electronically signed the monthly physician orders for June, July, and August 2022. 10. The surveyor reviewed the closed record of Resident #70 who resided at the facility for [redacted] review of the hybrid medical record failed to reveal signed physician orders for the resident's stay during June 2022 and July 2022. 11. The surveyor reviewed the closed record of Resident #147 who resided at the facility for over [redacted] as a [redacted] resident. A review of the hybrid medical record revealed the physician did not sign orders for June 2022, July 2022, and August 2022. 12.Resident #117's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, July 2022, or August 2022. 13. Resident #22's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, and July 2022. 14. Resident #7's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's	F 711		

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F 711	Continued From page 36 orders for June 2022, July 2022, or August 2022. 15. Resident #41's hybrid medical record revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, July 2022, or August 2022. 16. The hybrid medical records of Resident #37 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, July 2022, and August 2022. 17. The hybrid medical records of Resident #54 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, July 2022, and August 2022. 18. The hybrid medical records of Resident #38 revealed the resident's physician had not hand signed or electronically signed the monthly physician's orders for June 2022, July 2022, and August 2022. On 09/12/22 at 10:38 am, the surveyor interviewed a Registered Nurse (RN) regarding where the physicians sign the orders for residents. The RN stated the physicians usually sign in the resident's paper chart and the physicians may sometimes sign in the EHR. The RN stated the monthly POS are usually kept in a binder for the physicians to sign. The RN clarified the monthly POS were kept in the binder and once signed were to be returned to the resident's chart. On 09/12/12 at 11:50 am, the surveyor asked the RN/Unit Manager (RN/UM) about the monthly	F 711		

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POS for residents. The RN/UM stated there were binders on the unit for the physician to sign orders. The surveyor observed that the binders on the unit consisted only of monthly physician orders from 2020. The RN/UM stated the Director of Nursing (DON) had the current binders and would provide to the surveyor.

On 09/12/22 at 01:19 pm, the surveyor informed the Administrator, DON, and RN regional coordinator of the concerns with the monthly physician orders not found in the chart and the signing of the monthly POS by physicians. The DON stated there was a binder with monthly physician orders for the physicians to sign. The DON stated when the physicians visit, the staff have the physicians sign the POS and place it back in the resident's chart. The DON and Administrator stated they would provide further information to the surveyor.

On 09/14/22 at 1:42 PM, the surveyor discussed with the Administrator and the DON the signing of the POS by the physicians. The Administrator stated the physicians will be coming in to complete the signing of the June, July, and August 2022 POSs. The Administrator and DON did not provide a response as to why POSs were not signed. The surveyor asked who was responsible for ensuring the physician's signed orders for the residents. The Administrator replied the medical records staff was responsible.

On 9/15/22 at 9:49 am, the surveyor interviewed the Medical Records staff person (MR) about physicians signing orders and the monthly POS. The MR stated she was responsible for getting the POS together in the binders and getting the physician to sign them. The MR further stated she

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F 711	Continued From page 38 would call the physicians' office to see when they would be coming in and told the offices she could fax orders to be signed by the physicians. The MR stated she printed out the POS every month to prepare for physicians to sign. On 9/15/22 at 12:07 pm, the DON provided surveyor reviewed the facility's policy and procedure titled, "Electronic Medical Records", reviewed 01/2022, did not address physicians signing orders. No further information was provided by the facility.	F 711		
F 755 SS=D	NJAC 8:39- 23.2 (b) Pharmacy Srvcs/Procedures/Pharmacist/Records 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	F 755		10/28/22

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F 755	Continued From page 39 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 review of medical records and other facility documentation, it was determined that the facility failed to a) accurately follow the facility documentation policy related to the inventory control wasting of Ex Order 26. 4B1 and Ex Order 26. 4B1 control substance classes of medications for 2 of 20 residents who were receiving NJ Exec. Order 26:4.b.1 inspected on the 5th floor, Resident #61 and Resident #24, b) remove a discontinued NJ Exec. Order 26:4. from stock, and c) keep an accurate physical inventory of back up NJ Exec. Order 26:4.b.1 stored in a CUBEX system (automated medication dispensing system). This deficient practice was evidenced by the following: a) On 9/2/22 at 11:59 AM, the surveyor conducted a unit inspection which included an inventory comparison of the Individual Patient Controlled Substance Administration Record (CSAR) and physical NJ Exec. Order 26:4.b.1 inventory with the RN Nurse Manager(RNNM). When the RNNM presented the CSAR for Ex Order 26. 4B1 belonging to Resident #61 there was an entry dated 8/20/22 at 9 AM and signed by RNNM,	F 755	1- (a) Inservice was done for licensed nurse that wasted Ex Order 26. 4B1. on 8/20/22. Inservice was done on proper procedure for NJ Exec. Order 26:4.b.1 by DON/ADON/Designee. Inservice was also done for nurses that wasted Ex Order 26. 4B1. on 11/28/21 and 9/10/21. Inservice was done on proper procedure for NJ Exec. Order 26:4.b.1 by DON/ADON Designee. Inservice was done for nurses that NJ Exec. Order 26:4. med on 8/29/22 and 9/1/22. (b) Inservice was done for nurse responsible for auditing the medications for expiration date and removing them once they were expired. Inservice was done by DON/ADON Designee on monitoring expiration dates and removing the medication from the cart when expired. (c) Inservice was done for the RNCN from forth floor on the cubex daily inventory check which is to be done at least daily. the inservice was done by the DON/ADON/Designee. (d) Policy for NJ Exec. Order 26:4.b.1	

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F 755	Continued From page 40 documented Ex Order 26. 4B1 The RNNM stated that she found the Ex Order 26. 4B1 falling out of the sealed foil pack. When asked if there was a witness to this, the RNNM stated she forgot to get another witnessing nurse's signature on the CSAR, but that she was the nurse who wasted the medication. The CSAR for Ex Order 26. 4B1 contained documention of two entries on 9/10/21 and on 11/28/21 indicating, "Wasted" in the "Time" column. The 9/10/21 entry had one nurse's signature. Both entries on the CSAR failed to include a time that the 2 doses were wasted. A review of the CSAR revealed two entries on 8/29/22 and 9/1/22 indicating "Wasted" in the "Time" column. Both entries were signed by two nurses but failed to include a time that these 2 doses were wasted. b) The CSAR contained documention that there were NJ Exec. Order 26 4.b.1 of Ex Order 26. 4B1 belonging to Resident #24, found in inventory and this was the correct amount that was physically present. The CSAR contained documention of Ex Order 26. 4B1 of Ex Order 26. 4B1 delivered by the Provider Pharmacy on 7/16/21 for Resident #24, had a documented expiration date on the medication seal of 7/15/22. Review of the CSAR had entries for 9/10/21, 11/28/21, 2/17/21, 2/22/21, 7/3/22 and 8/20/22. The original order for Ex Order 26. 4B1 dated 7/16/21 was ordered with a discontinuation date of 7 days later for Resident #24. The Ex Order 26. 4B1 was then discontinued on 7/24/21. The medication remained in the locked NJ Exec. Order 26:4.b. section of the medication cart, despite the order	F 755	NJ Exec. Order 26 4.b.1 inventory for backup box & Emergency kits were reviewed and revised by LNHA/Designee. 2-All residents receiving medication may be affected. They may be identified by reviewing the POS & MAR. 3- Inservice for all licensed nurses done for NJ Exec. Order 26:4.b.1, monitoring medication for expiration dates and dubex daily inventory check. This inservice was done by DON/ADON/Designee. Inservice also includes policy on NJ Exec. Order 26:4.b.1 substances. Dubex daily inventory check will be done at least daily by designated nurse. Any issues will be immediately addressed and reported to the LNHA/DON. 4- Audit of the Dubex daily inventory check will be done at least monthly by the LNHA/Designee. Results will be reported to the LNHA and QA Committee at least quarterly. Review of the NJ Exec. Order 26 4.b.1 sheet will also be done monthly by the LNHA/designee. Any issues will be immediately addressed. Results will be reported to the LNHA and QA Committee at least quarterly.	

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being discontinued until 9/2/22, when the surveyor noted the medication.

c) On 9/12/22 at 11:05 AM, the surveyor interviewed the 4th floor Registered Nurse Charge Nurse (RNCN) in reference to the CUBEX system. The CUBEX system was located in the locked medication room on the 4th floor. The surveyor discussed the inventory process of the control substance medications that were stored in the CUBEX system. The RNCN informed the surveyor no inventory was completed during her shift. The RNCN presented a bound book to the surveyor titled, "Cubex Daily Inventory Check book." The surveyor reviewed the "Cubex Daily Inventory Check" which indicated that the last time inventory was performed was 3/11/2019 with "NO" documented under the discrepancy column.

On 9/13/22 at 9:49 AM, the surveyor in the presence of the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) completed a physical count of all controlled substance medications in the CUBEX system. Although the CUBEX system presented an automated inventory of *Ex Order 26. 4B1* [redacted], there were no physical tablets in the area designated for this medication. *Ex Order 26. 4B1* is a *Ex Order 26. 4B1* [redacted] control substance medication. Further information obtained from the CUBEX system established that the last entry into the CUBEX system for this medication was on 2/9/21 at 6:02 PM.

On 9/13/22 at 12:42 PM, the surveyor interviewed the Consultant Pharmacist (CRPh) who was not

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F 755	Continued From page 42 aware that the facility failed to perform daily inventory counts of back up narcotics stored in the CUBEX system. The CRPh informed the surveyor that she does not have access to the CUBEX system. On 9/14/22 at 10:20 AM, the surveyor interviewed the Provider Pharmacy Account Executive (PPAE), who explained the Cubex provides the ability to do a physical count of the narcotic inventory through an option "Cycle Count." The PPAE stated that the facility should perform a physical control substance count of all medications stored in the CUBEX system at least once daily. The PPAE was able to review the past history for *Ex Order 26. 4B1* and informed the surveyor that the medication was delivered on 2/9/21 with a documented expiration date in 2/10/22. There was no evident information to show that the medication was removed or destroyed because it had expired. No documentation was available that the medication had been removed or destroyed due to expiring . The PPAE informed the surveyor electronic inventory sheets which include all control substance medications are sent out by email daily. The PPAE also informed the surveyor that a technician comes to the facility monthly from the Pharmacy Provider to remove all expired non control substance medications. The technician does not have access to any control substances stored in the CUBEX system, this is the responsibility of the facility. The PPAE added that the electronic inventory is only as accurate as the CUBEX information updated by the facility.	F 755		

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F 755	Continued From page 43 The surveyor reviewed the Controlled Dangerous Substance Inventory for Back Up Box and Emergency Kits policy. The policy stated, "4. In the event a controlled substance medication in the emergency supply box inventory expires, it must be immediately destroyed at the facility per facility policy and procedure." Attached to the policy was the CUBEX Daily Inventory Check that specified "For the Month Of:" and included columns for "Incoming (RN#1) Outgoing (RN#2)" "Discrepancies Y or N" and "Resolution." This CUBEX Daily Inventory Check was provided to the surveyor by the DON who explained that this reporting paper should have been filled out daily. Review of the Controlled Substances policy indicated "9. Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services." Review of the facility policy "Discarding and Destroying Medications" approved 1/2022 indicated "7. The medication disposition record must contain, as a minimum, the following information: i. Signature of witnesses." On 9/2/22 at 2:15 PM, the surveyor met with the DON and Licensed Nursing Home Administrator (LNHA) to discuss findings concerning the discrepancies with control substance management at the facility. On 9/12/22 at 1:26 PM, the surveyor met with the DON in the presence of LNHA and the RN Clinical Support Regional staff person to discuss further findings concerning the discrepancies with	F 755		

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F 755	Continued From page 44 control substance management at the facility. No further information was provided to the survey team. On 9/14/22 at 10:04 AM the surveyor met with the DON in the presence of the ADON, PPAE and the LNHA to discuss further findings concerning the discrepancies with control substance management at the facility. The DON stated that inventory of controlled substance medication should be performed daily. The DON added that when medications are wasted, there needs to be two nurses' signatures on the inventory sheet. On 9/15/21 at 10:15 AM, the surveyor discussed the expired *Ex Order 26. 4B1* found in the locked NJ Exec. Order 26:4.b. box of 5th floor the medication cart on 9/2/22. The DON agreed that the *Ex Order 26. 4B1* should have been removed from stock and destroyed once the 7/16/21 order was discontinued on 7/24/21. The NJ Exec. Order 26:4.b.1 should not have remained in the medication cart. On 9/15/22 at 12:53 PM, the surveyor discussed all the controlled substance medication issues with the DON and LNHA during the survey exit via a phone call. No further information was provided by the facility to the survey team.	F 755		
F 849 SS=D	NJAC 8:39- 29.4(b)2 Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Ex Order 26. 4B1 services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of Ex Order 26. 4B1 services through an agreement with one or more	F 849		10/28/22

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F 849	Continued From page 45 Medicare-certified [Ex Order 26. 4B1]. (ii) Not arrange for the provision of [Ex Order 26. 4B1] services at the facility through an agreement with a Medicare-certified [Ex Order 26. 4B1] and assist the resident in transferring to a facility that will arrange for the provision of [Ex Order 26. 4B1] services when a resident requests a transfer. §483.70(o)(2) If [Ex Order 26. 4B1] care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a [Ex Order 26. 4B1], the LTC facility must meet the following requirements: (i) Ensure that the [Ex Order 26. 4B1] services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the [Ex Order 26. 4B1] that is signed by an authorized representative of the [Ex Order 26. 4B1] and an authorized representative of the LTC facility before [Ex Order 26. 4B1] care is furnished to any resident. The written agreement must set out at least the following: (A) The services the [Ex Order 26. 4B1] will provide. (B) The [Ex Order 26. 4B1] responsibilities for determining the appropriate [Ex Order 26. 4B1] plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the [Ex Order 26. 4B1] provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the [Ex Order 26. 4B1] about the following: (1) A significant change in the resident's physical, mental, social, or emotional status.	F 849		

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F 849	Continued From page 46 (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the [redacted] assumes responsibility for determining the appropriate course of [redacted] care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the [redacted] representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the [redacted] responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other [redacted] services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed [redacted], including those [redacted] determined appropriate by the [redacted] and delineated in the [redacted] plan of care, the LTC facility personnel may administer the [redacted] where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving	F 849		

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F 849	Continued From page 47 mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by Ex Order 26. 4B1 personnel, to the Ex Order 26. 4B1 administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the Ex Order 26. 4B1 and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of Ex Order 26. 4B1 care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with Ex Order 26. 4B1 representatives to coordinate care to the resident provided by the LTC facility staff and Ex Order 26. 4B1 staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with Ex Order 26. 4B1 representatives and coordinating LTC facility staff participation in the Ex Order 26. 4B1 care planning process for those residents receiving these services. (ii) Communicating with Ex Order 26. 4B1 representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the Ex Order 26. 4B1 medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient	F 849		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING _____ B. WING _____	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE JERSEY CITY, NJ 07307**

(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 849	Continued From page 48 as needed to coordinate the Ex Order 26. 4B1 care with the medical care provided by other physicians. (iv) Obtaining the following information from the Ex Order 26. 4B1: (A) The most recent Ex Order 26. 4B1 plan of care specific to each patient. (B) Ex Order 26. 4B1 election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for Ex Order 26. 4B1 personnel involved in Ex Order 26. 4B1 care of each patient. (E) Instructions on how to access the Ex Order 26. 4B1 24-hour on-call system. (F) Ex Order 26. 4B1 medication information specific to each patient. (G) Ex Order 26. 4B1 physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to Ex Order 26. 4B1 staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing Ex Order 26. 4B1 care under a written agreement must ensure that each resident's written plan of care includes both the most recent Ex Order 26. 4B1 plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and Ex Order 26. 4B1 well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to consistently provide coordination between facility staff and Ex Order 26. 4B1 agency staff to meet the resident's needs. This deficient practice was	F 849	1-Meeting held with Grace Ex Order 26. 4B1 team and Optima Care Harbor View Management staff to discuss the need for current notes from the Ex Order 26. 4B1 staff. Notes were received from the Ex Order 26. 4B1	

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	315310	A. BUILDING _____ B. WING _____	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE JERSEY CITY, NJ 07307**

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F 849	Continued From page 49 identified for 1 of 29 residents, Resident #87, reviewed for Ex Order 26. 4B1 care. The deficient practice was evidenced by the following: On 9/6/22 at 10:56 AM, the surveyor observed Resident #87 in bed sleeping. On 9/7/22 at 11:53 AM, the Licensed Practical Nurse (LPN) informed the surveyor that Resident #87 was on Ex Order 26. 4B1. The LPN further stated that the Ex Order 26. 4B1 nurse came to the facility once or twice a week. The surveyor reviewed the resident's medical records which revealed the following: A review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility with a diagnosis that included but was not limited to Ex Order 26. 4B1 [redacted]. A recent quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate care management dated 6/17/22, revealed a Brief Interview for Mental Status score of Ex Ord, which indicated that the resident was NJ Exec. Order 26:4.b.1 [redacted]. A Physician's Order which revealed the following: Ex Order 26. 4B1 Care: NJ Exec. Order 26 with an order date of 1/9/2020. A review of the resident's medical record revealed there were no Ex Order 26. 4B1 nurse visit notes after July 11, 2022.	F 849	nurse to bring the Ex Order 26. 4B1 notes up to date. Policy on "Ex Order 26. 4B1 services" was reviewed and revised by the Licensed Nursing Home Administrator/Designee. 2- All residents on Ex Order 26. 4B1 may be affected. They may be identified by reviewing the physicians orders for Ex Order 26. 4B1 services. All residents receiving Ex Order 26. 4B1 services were reviewed to ensure that notes up to current date were present. 3- Inservice done for all licensed nurses on Ex Order 26. 4B1 services done by the Ex Order 26. 4B1 RN. Inservice to include need for Ex Order 26. 4B1 nurse to provide notes at time of visit so that the communication concerning the residents needs may remain current. Director of Nursing/Assistant Director of Nursing/Designee will monitor the Ex Order 26. 4B1 residents on a monthly basis to ensure current notes are received from the Ex Order 26. 4B1 staff. Results will be immediately addressed and reported to the Licensed Nursing Home Administrator. 4- Audit will be done monthly for all Ex Order 26. 4B1 residents to ensure all Ex Order 26. 4B1 notes are current. This will be done by the Licensed Nursing Home Administrator/Designee. Any issues will be immediately addressed and results will be reported to the Licensed Nursing Home Administrator and Quality Assurance Committee at least quarterly.	

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
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE JERSEY CITY, NJ 07307**

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F 849	Continued From page 50 On 9/7/22 at 12:45 PM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM) and asked her who was responsible for making sure that the [redacted] visit notes were in Resident #87's medical record. The RN/UM stated, [redacted] She further stated that the [redacted] nurse would give a verbal report to the nurse on duty and place the [redacted] visit note in the resident's medical record for every visit. The RN/UM acknowledged that the last [redacted] visit note titled NJ Exec. Order 26:4.b.1 Note" was dated 7/11/22. On 9/9/22 at 10:18 AM, the surveyor called the [redacted] Nurse/HN. The HN stated that she documented her [redacted] visit notes on her laptop and gave verbal reports to the nurse on duty before she left the facility. She further stated that she printed her [redacted] visit notes titled [redacted] every 2 weeks and placed them in the resident's medical record. The HN acknowledged that she should have printed her [redacted] visit notes for every visit. On 9/12/22 at 1:30 PM, the surveyors met with the Licensed Nursing Home Administrator, Director of Nursing (DON), and Regional Clinical Nurse and discussed the above concern. No further information was provided. A review of the facility policy titled [redacted] with an approved date of 7/5/22 did not include medical records information. A review of Grace Healthcare Services Agreement for Nursing Facility Services signed	F 849		

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	315310	A. BUILDING _____ B. WING _____	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE JERSEY CITY, NJ 07307**

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F 849	Continued From page 51 on 1/18/13 included "4.3 Communication. Ex Order 26. 4B1 and Facility will communicate pertinent information with each other either verbally or in the patient's medical record at each Ex Order 26. 4B1 patient visit to ensure that the needs of each Ex Order 26. 4B1 patient are met 24 hours a day. Documentation of such communication shall be included in the patient's medical record." On 9/13/22 at 12:09 PM, the surveyor interviewed the DON in the presence of another surveyor and asked her who was responsible for making sure the Ex Order 26. 4B1 visitation notes were placed in the resident's medical record. She stated, "The unit manager and the nurse on duty now and then." The surveyor asked the DON what would be done if the hospice visitation notes were not in the resident's medical record. The DON further stated, [redacted] NJAC 8:39-27.1 (a)	F 849		

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
	060905	A. BUILDING: _____ B. WING _____	09/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

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S 000	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	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 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:	S 560	1- In order to increase the number of CNA's we are running ad's and have signed up two agencies to provide us with additional CNA's. Inservice was done for the nursing management on the subject of meeting the CNA to resident ratios. Three CNA's were hired for October 2022; two for the 11-7 shift and one for the 3-11 shift. 2- All residents may be affected by staffing ratio issues. They may be identified by reviewing staffing sheets & census numbers. 3- Director of Nursing/Assistant Director of Nursing/Designee will complete bi-weekly audit of staffing to ensure CNA numbers meet the needed ratio for the CNA's. Results reported to the Licensed Nursing Home Administrator & Quality Assurance Committee at least monthly and any reasons for discrepancies will be documented.	10/28/22

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

Electronically Signed | 10/14/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060905	A. BUILDING: _____ B. WING _____	09/19/2022

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OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

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S 560	Continued From page 1 (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. (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	S 560	Administrator will run ads as needed to increase CNA hires. 4- An audit of staffing will be done by the Licensed Nursing Home Administrator/Director of Nursing/Designee done once monthly. This will be a review of staffing numbers versus staffing ratio. Any discrepancies will be reported to the Licensed Nursing Home Administrator & Quality Assurance Committee at least monthly and any discrepancies will be resolved immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 2 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 8/14/22 and ending 8/27/22 revealed the facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs on 4 of 14 day shifts and total staff on 2 of 14 overnight shifts as follows: -08/14/22 had 12 CNAs for 136 residents on the day shift, required 17 CNAs. -08/20/22 had 14 CNAs for 130 residents on the day shift, required 16 CNAs. -08/21/22 had 12 CNAs for 123 residents on the day shift, required 15 CNAs. -08/27/22 had 12 CNAs for 129 residents on the day shift, required 16 CNAs. -08/16/22 had 8 total staff for 134 residents on the overnight shift, required 10 total staff. -08/19/22 had 8 total staff for 130 residents on the overnight shift, required 9 total staff. On 9/15/21 at 1:30 PM, the surveyor discussed the staffing ratio concerns with the Administrator and Director of Nursing, who stated they were aware of the staffing ratio criteria.	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
315310 Y1	A. Building B. Wing Y2	12/14/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

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 F0558	Correction	ID Prefix F0584	Correction	ID Prefix F0640	Correction
Reg. # 483.10(e)(3)	Completed	Reg. # 483.10(i)(1)-(7)	Completed	Reg. # 483.20(f)(1)-(4)	Completed
LSC	10/28/2022	LSC	10/28/2022	LSC	10/28/2022
ID Prefix F0656	Correction	ID Prefix F0657	Correction	ID Prefix F0658	Correction
Reg. # 483.21(b)(1)	Completed	Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	10/28/2022	LSC	10/28/2022	LSC	10/28/2022
ID Prefix F0689	Correction	ID Prefix F0698	Correction	ID Prefix F0711	Correction
Reg. # 483.25(d)(1)(2)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.30(b)(1)-(3)	Completed
LSC	10/28/2022	LSC	10/28/2022	LSC	10/28/2022
ID Prefix F0755	Correction	ID Prefix F0849	Correction	ID Prefix	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.70(o)(1)-(4)	Completed	Reg. #	Completed
LSC	10/28/2022	LSC	10/28/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/19/2022	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060905 Y1	A. Building B. Wing Y2	12/14/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

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 10/28/2022	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
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 9/19/2022	☐ 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
	315310	A. BUILDING **01** B. WING _____	**09/19/2022**

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OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE** **JERSEY CITY, NJ 07307**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/19/22 and 09/20/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The building is a 5-story facility, that was built in 90's, It is composed of Type II protected construction. The facility is divided into 13- smoke zones. The generator is a Cummins 200 KW. The facility currently has no Maintenance Director and the Regional Plant Operations Director performed the building tour. A newly hired Maintenance Director will start October 1, 2022.	K 000		
K 211 SS=F	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 by: Based on observations, interview and documentation review on 9/19/22, in the presence of the Regional Plant Operations Director, it was determined that the facility failed to inspect fire doors annually in accordance with	K 211	1- All residents may be affected by this. They may be identified by reviewing the daily census. 2- An inspection of all doors was completed by the maintenance director	10/28/22

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

Electronically Signed | 10/14/2022

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
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE** **JERSEY CITY, NJ 07307**

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K 211	Continued From page 1 S&C 17-38-LSC. This deficient practice occurred for 12 of 12 fire doors observed, and was evidenced by the following: From approximately 10:00 AM to 2:00 PM, the surveyor reviewed all documentation provided from the Regional Plant Operations Director. The annual fire door inspection documentation was not provided for the facility's fire door assemblies. An interview was conducted with the Regional Plant Operations Director, during the document review. He stated that currently he could not provide any documentation for the last 12-months as identified in the S&C 17-38-LSC documentation. The Administrator was informed of the finding's at the Life Safety Code exit conference held on 09/20/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 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	and any issues were immediately addressed. Results were reported to the administrator and the quality assurance committee at least monthly. The annual fire door inspection shall be audited monthly by the maintenance director/designee to ensure completion of the inspection. Results will be reported to the administrator and the quality assurance committee at least monthly. Any discrepancies will be immediately addressed. 3- An audit of the annual fire door inspection will be done quarterly by the administrator/designee to ensure completion of the annual inspection. The results were reported to the administrator and the quality assurance committee at least quarterly. Any issues will be immediately addressed.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements:	K 222		10/28/22

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OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE** **JERSEY CITY, NJ 07307**

(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 222	Continued From page 2 CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS	K 222		

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K 222	Continued From page 3 Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/20/22, it was determined that the facility failed to ensure that exit doors locked with a delayed egress device were provided with instructional signage as per the requirements of NFPA 101:2012 - Chapter 7.2.1.6.1.1(4). This deficient practice was identified in 2 of 8 egress doors and evidenced by the following: 1. At 10:55 AM, the Surveyor, Regional Plant Operations Director, observed that the exit/egress door by stair-A, was provided with a delayed egress system. The door was not provided with a readily visible sign with 1-inch letters indicating "Push Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button keypad and opened with the activation of the fire alarm. 2. At 11:18 AM, the Surveyor, Regional Plant Operations Director, observed that the exit/egress door stair-B ,was provided with a delayed egress system. The door was not provided with a readily visible sign with 1-inch letters indicating "Push	K 222	1- Exit/Egress door by stair A had installed a readily visible sign indicating "push until alarm sounds , door can be opened in 15 seconds". - Exit/Egress door by stair B had installed a readily visible sign indicating "push until alarm sounds , door can be opened in 15 seconds". - An inspection of all doors was completed by the director of maintenance services to ensure all doors have needed signage. Results were reported to the administrator and Quality Assurance committee at least monthly. 2- All residents can be affected by this issue. They can be identified by reviewing the census list. 3- An inspection audit will be completed monthly by the director of maintenance/designee to ensure that doors requiring signage will maintain the signage. Results will be reported to the administrator and Quality Assurance committee at least monthly.	

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K 222	Continued From page 4 Until Alarm Sounds, Door Can Be Opened in 15-Seconds." The door was provided with a push button keypad and opened with the activation of the fire alarm. The Regional Plant Operations Director, confirmed the findings at the time of the observations. The Administrator was informed of these findings, during the Life Safety Code survey exit conference on 9/20/22. NJAC 8:39-31.2(e) NFPA 101:2012 - 7.2.1.6.1(4)	K 222	4- An audit of all the doors will be done quarterly by the Administrator/designee. Any issues will be immediately addressed and reported to the Administrator and Quality Assurance committee at least quarterly.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interviews conducted on 9/20/22, in the presence of the Regional Plant Operations Director, it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 1 of 10 units observed and was evidenced by the following: At 11:30 AM, the facility main dining room was	K 281	1- Main dining room - electrical wall switches were reviewed by electrician and one switch adjusted to remain on. 2- Any residents utilizing the main dining room may be affected by this practice. They may be identified by reviewing the dietary list of residents attending the main dining room. 3- The dining room lights will be routinely checked once a week, and bulbs replaced as needed. That weekly check will be	10/28/22

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K 281	Continued From page 5 observed to have 6 electrical wall switches. The surveyor revealed that when all 6-switches were shutoff the large approximately 40' x 40' room had no lighting. The findings were verified by the Regional Plant Operations Director at the time of the observation's. The Administrator was informed of the finding's at the Life Safety Code exit conference on 9/20/22. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	documented and completed by the maintenance department. 4- An audit of the dining room lights will be done by Licensed Nursing Home Administrator/Designee monthly. Results will be reported the Licensed Nursing Home Administrator & Quality Assurance Committee at least quarterly.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353		10/28/22

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K 353	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on surveyor observation on 9/20/22 in the presence of the Regional Plant Operations Director, it was determined that the facility A).failed to maintain all parts of their automatic sprinkler system in optimal condition B). ensure all backflow prevention device assemblies were in operation as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. This deficient practice was evidenced by the following: A). At 11:48 AM, the surveyor observed 4 of 15 sprinkler heads outside the building's overhang, approximately 40' x 30' that 4 of the fire sprinkler heads were missing the recessed escutcheon finish plate's, exposing the fire sprinkler heads. The missing covers revealed a green coating of oxidation/corrosion on the fire sprinkler heads. The area under the building overhang was used as a parking lot at the time of observation. An interviewed was conducted with the Regional Plant Operations Director at the time of the observation's, where he stated and confirmed 4 of 15 fire sprinkler heads were missing covers and the exposed heads had a green coating of oxidation/corrosion. B). Record review of the annual backflow prevention device assembly test report indicated on 8/8/22, the facility fire sprinkler vendor failed the fire service line check valve #1 marked: leaked, as the "device leaks catastrophically from the first check and should be rebuilt". The device was left out of service. The Regional Plant Operations Director confirmed the fire sprinkler vendor report dated	K 353	1- (a)Four of fifteen sprinkler heads under the overhang outside that were missing recessed escutcheon finish plates and having oxidation were inspected by sprinkler company and proposal given to repair sprinkler heads. (b) Fire service line check valves #1 was inspected and proposal given for repair. Both A & B repairs were completed by the sprinkler company. 2- All residents using that area may be affected. They may be identified by reviewing the census. 3- The area under the overhang outside will be inspected monthly by the maintenance director/designee. The inspection will be for missing escutcheon plates and any oxidation. Any issues will be immediately addressed and results reported to the administrator and QA Committee. 4- An audit will be done at least quarterly by the LNHA/Designee Any issues will be immediately addressed and results reported to the Licensed Nursing Home Administrator & Quality Assurance Committee at least quarterly.	

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K 353	Continued From page 7 8/8/22 indicating the device failure. The Administrator was informed of the finding's at the Life Safety Code exit conference on 9/20/22. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In	K 363		10/28/22

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K 363	Continued From page 8 sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 9/20/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in 8 of 50 resident room doors observed and was evidenced by the following: during the building tour from 9:15 AM to 2:00 PM, the surveyor and Regional Plant Operations Director toured the facility and observed the following: Resident Room # 311 will not latch, hardware issue. Resident Room # 320 would not close due to a resident nightstand blocking the door. Resident Room # 329 the door rubs into its frame. Resident Room # 401 the door rubs into its frame. Resident Room # 409 will not latch, hardware issue. Resident Room # 509 the door sticks to the top	K 363	The following doors were repaired and latch as needed: Room 311- hardware issue, Room 320-nightstand blocking door, Room 329-door nubs into frame, Room 401-door nubs into frame, Room 409-will not latch hardware, Room 509-sticks to the top of the doorframe, Room 512-door not catching, Room 525-sticks to frame paint. Inservice was done for all staff on need to report any issues with doors in the maintenance log book. 2- The residents in the above mentioned rooms may be affected. They may be identified by reviewing the census showing room numbers. 3- Room doors will be routinely checked as part of preventative maintenance at least monthly by the maintenance director/designee. Any issues will be immediately addressed. Results will be reported to the Licensed Nursing Home Administrator/Quality Assurance Committee at least monthly. 4- An audit will be done by the maintenance director/designee at least quarterly to ensure that all doors latch properly. Results reported to the	

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K 363	Continued From page 9 of the door frame. Resident Room # 512 the door would not latch into its frame. Resident Room # 525 The door sticks to the frame from being painted. At the time of observations, the surveyor interviewed the Regional Plant Operations Director, who confirmed the above findings. The Administrator were informed of the finding's at the Life Safety Code Exit Conference on 9/20/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	administrator & Quality Asurance committee. Any issues will be immediately addressed.	
K 521 SS=F	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, record review and interview on 9/20/22, in the presence of the Regional Plant Operations Director, it was determined that the facility failed to provide smoke dampers for 6 of 6 corridor vents identified (north, south, and east) shafts observed. This	K 521	Smoke dampers for six of six corridor vents identified were inspected by an outside vendor and a proposal was given for repair. The repairs were completed. 2- All residents residing here may be affected. They may be identified by	12/7/22

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K 521	Continued From page 10 deficient practice was evidenced by the following: The Surveyor and Regional Plant Operations Director observed wall transfer grills approximately 2' x 18" and 2' x 2' open grills on floors 3, 4, and 5. The Regional Plant Operations Director confirmed the locations and stated that he was not sure if the grills on floors 3, 4, and 5 have fire dampers and/or other approved means to resist the transfer of smoke into areas of refuge on each floor. The Administrator was informed of the finding at the Life Safety Code exit conference on 9/20/22. NFPA 90 A NFPA 101-2012 edition Life Safety Code NFPA 101-19.5.2.1 section 9.2.2 NFPA 101 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NFPA 101 19.3.6.4.1 Transfer grills, regardless of whether they are protected by fusible link dampers, shall not be used in corridor walls or doors. NJAC 8:39-31.2(e)	K 521	reviewing the census. 3- Smoke dampers will be checked for function every other week by the maintenance director/designee. Any issues will be immediately addressed. Results will be reported to the Licensed Nursing Home Administrator and Quality Assurance committee at least monthly. 4- An audit of the smoke dampers for function will be done monthly by the Licensed Nursing Home Administrator/Designee. Issues will be immediately addressed. Results reported to the Licensed Nursing Home Administrator & Quality Assurance Committee at least monthly.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the	K 531		10/28/22

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K 531	Continued From page 11 level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 9/19/22, it was determined that the facility failed to ensure that elevators' firefighters service was operated monthly with a written record for 2 of 2 elevator devices, in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. This deficient practice was evidenced by the following: During record review on with the surveyor, Regional Plant Operations Director, there was no documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3. An interview was conducted with the Regional Plant Operations Director, during the record review they confirmed currently there is no firefighter's monthly service log.	K 531	1- Maintenance director and assistant reviewed inservice on keeping a monthly elevator service log. Elevator service log was maintained by the maintenance department. 2- All residents using the elevator may be affected. They may be identified by reviewing the census for whoever resides above the lobby floor. 3- Monthly service log will be maintained by the maintenance director/assistant It will include the monthly tests for each car. 4- Audits of the monthly service logs will be done by the administrator and initials will be placed on log to indicate review. Any issues will be addressed immediately and reported to the Licensed Nursing Home Administrator and Quality Assurance committee at least quarterly.	

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K 531	Continued From page 12 The Administrator was informed of this issue at the Life Safety Code exit conference on 9/20/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531		
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 readily available. EES electrical panels and circuits are marked, readily identifiable, and	K 918		10/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING **01** B. WING _____	**09/19/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE** **JERSEY CITY, NJ 07307**

(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 918	Continued From page 13 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 9/19/22, 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 evidenced for 1 of 1 generator logs provided by the Regional Plant Operations Director by the following: On 9/19/22, a review of the generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the Maintenance Director was performing a monthly load test, but he was not recording the required transfer times on the provided document. An interview was conducted with the Maintenance Director and Regional Plant Operations Director, where they confirmed 12 of 12 months did not have any documented transfer times. The Administrator was informed of the finding at the LSC exit conference on 9/20/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99	K 918	1-Maintenance director/assistant/designee were inserviced on need for generator log showing minimal transfer time of ten seconds. Maintenance director/assistant/designee updated log to include transfer time. Policy on generator was reviewed and revised by the Licensed Nursing Home Administrator. 2- All residents residing in the facility may be at affected by this practice. They may be identified by reviewing the census. 3- Monthly generator testing log was done we added the certification of time needed by generator to transfer proves to the building was within the required ten second time. 4- An audit will be done monthly by the administrator/designee to ensure that transfer time is recorded in the log. Any issues will be immediately addressed. Results reported to the licensed nursing home administrator and Quality Assurance committee at least monthtly.	

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K 918	Continued From page 14 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 Standard for Emergency and Standby Power Systems	K 918		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full	K 923		10/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING 01 B. WING	09/19/2022

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OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

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K 923	Continued From page 15 cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and interview on 9/20/22 in the presence of the Regional Plant Operations Director, it was determined that the facility failed to store cylinders of compressed oxygen in a manner that would protect the cylinders against tipping, rupture and damage in accordance with NFPA 99. This deficient practice was identified for 1 of 20 portable oxygen cylinders and was evidenced by the following: At 11:10 AM, the surveyor observed in resident room 319 that one Ex Order 26. 4B1 was freestanding in the corner of the resident room unsecured. An interview was conducted with the Regional Plant Operations Director, who stated that the Ex Order 26. 4B1 observed, must be secured from tipping, rupture and damage at all times in the facility. The Administrator was informed of the finding at the Life Safety Code exit conference on 9/20/22. NJAC 8:39-31.2(e) NFPA 99	K 923	1- One freestanding Ex Order 26. 4B1 in room 319 was removed and secured. Nursing staff responsible for room 319 was inserviced on Ex Order 26. 4B1 storage. The maintenance staff was also inserviced on the Ex Order 26. 4B1 policy regarding storage and security. 2- Any resident using NJ Exec. Order 26:4.b may be affected by this practice. They may be identified by reviewing the MD's orders for NJ Exec. Order 26:4.b A sample of five residents with NJ Exec. Order 26:4. NJ Exec. Order 26 was reviewed and all were secured properly. 3- Inservice was done for all nursing staff on proper storage of NJ Exec. Order 26:4.b.1 . Audit of ten NJ Exec. Order 26:4.b.1 done monthly by the Director of Nursing/Assistant Director of Nursing/Designee, to ensure proper storage of the NJ Exec. Order 26:4.b.1 . Any issues will be addressed immediately and the results will be reported to the administrator/QA Committee. 4- Audit of five residents with NJ Exec. Order 26:4.b done monthly by administrator/designee to ensure safe storage. Any issues will be immediately addressed and reported to the administrator and Quality Assurance committee at least quarterly.	

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	315310	A. BUILDING **01** B. WING _____	R **12/14/2022**

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{K 000}	INITIAL COMMENTS	{K 000}		
{K 211} SS=F	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 by:	{K 211}		
{K 222} SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the	{K 222}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 222}	Continued From page 1 safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4	{K 222}		

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{K 222}	Continued From page 2 This REQUIREMENT is not met as evidenced by:	{K 222}		
{K 281} SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by:	{K 281}		
{K 353} SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	{K 353}		

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{K 353}	Continued From page 3 This REQUIREMENT is not met as evidenced by:	{K 353}		
{K 363} SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	{K 363}		

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{K 363}	Continued From page 4 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by:	{K 363}		
{K 521} SS=F	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:	{K 521}		
{K 531} SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the	{K 531}		

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{K 531}	Continued From page 5 level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by:	{K 531}		
{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	{K 918}		

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{K 918}	Continued From page 6 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and 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:	{K 918}		
{K 923} SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be	{K 923}		

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{K 923}	Continued From page 7 handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:	{K 923}		

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
315310 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/14/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

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 K0211	10/28/2022	LSC K0222	10/28/2022	LSC K0281	10/28/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	10/28/2022	LSC K0363	10/28/2022	LSC K0521	12/07/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0531	10/28/2022	LSC K0918	10/28/2022	LSC K0923	10/28/2022
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	
9/19/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO