STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315112	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudsonview Health Care Center	9020 Wall Street North Bergen, NJ 07047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the interview, medical record review, and review of other pertinent documentation, it was determined that the facility failed to ensure that residents who receive hemodialysis (HD, a medical procedure used to treat kidney failure) receive such services consistent with professional standards of practice for 3 of 3 residents (Resident #2, #11, and #220) reviewed for dialysis services. The deficient practice was evidenced by the following: 1.The surveyor observed Resident #2 seated in a wheelchair in the unit day room on 7/28/25 at 10:47 am. The resident was brought to their room by staff so that the surveyor could interview the resident in a private area. The surveyor interviewed the resident with the aid of an interpreter since the resident was non-English speaking. The resident stated they receive HD on Monday, Wednesday, and Friday leaving the facility at 2 pm for the 3 pm HD appointment. The resident stated they sometimes get back to the facility as late as 8 pm at which time they eat dinner. The resident stated they are frequently not assessed by the nurse prior to leaving for the HD clinic at 2 pm. A review of the electronic medical record revealed the following information. The resident was admitted with diagnoses including but not limited to chronic kidney disease and dependence on renal hemodialysis. The Order Summary Report included physician's orders for HD on Monday, Wednesday, and Friday with a pickup time of 2 pm and appointment time of 3 pm. The Hemodialysis Report (a 1-page form brought to and back from the HD clinic) included documentation from the HD clinic nurse and post dialysis information and assessment written by the facility nurse upon the resident's return to the facility. The form did not have a section for pre dialysis information and assessment by the facility nurse. A review of July 2025 electronic progress notes failed to reveal pre dialysis nursing assessments. The July 2025 Medication Administration Report included nursing documentation for the following medications which were charted to have been given on Mondays, Wednesdays, and Fridays when the resident was out of the building at HD: Folic Acid 400 micrograms, Ferrous Sulfate 325 milligrams (MG), and Vitamin C 250 MG. The surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident #2 on 7/28/2025 at 11:18 am. The LPN stated nursing should check vital signs and the HD access site prior to the resident leaving the facility and upon return to the facility from the HD clinic. The LPN was unclear where the pre dialysis assessment should be documented. (continued on next page)

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

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The surveyor interviewed the Registered Nurse Unit Manager (RNUM) on 7/29/2025 at 10:45 am. The RNUM stated she expected nurses to document pre dialysis vital signs and access site assessment in the electronic progress notes. The RNUM stated she was aware that pre dialysis nursing assessments were inconsistent and stated she is going to formulate a new form with a top section for pre dialysis assessment. The RNUM did not discuss medications marked as given when the resident was out of the building. The surveyor discussed concerns with the Administrator and the [NAME] President of Clinical Services (VPCS) on 7/29/2025 at 12:52 pm. 2. On 07/29/2025 at 9:32 AM, the surveyor observed Resident #11 sitting on the bed in the room, lying in bed, and able to answer the surveyor's inquiries. The resident stated that they go to dialysis every Monday, Wednesday, and Friday, and leave at around 8:30 AM. On 07/29/2025 10:35 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #11, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #11 was admitted with diagnoses that included, but were not limited to, end-stage renal disease (ESRD, the kidneys can no longer function). A review of the recent quarterly Minimum Data Set (Q/MDS), (an assessment tool used to facilitate the management of care), dated 7/11/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had intact cognition. Further review of the A/MDS in Section O – Special Treatments, Procedures, and Programs stated that Resident #11 is on dialysis while a resident. A review of the Order Summary Report (OSR) with a start date on 5/21/25 revealed an order of dialysis days Monday, Wednesday, and Friday at [facility name redacted] chair time 9:30 AM, pick up time at 8:30 AM. 3. On 07/28/2025 at 10:45 AM, the surveyor observed Resident #220 in bed, awake, alert, who stated that they came back from dialysis this morning and have been attending hemodialysis for more than five years now. On 07/28/2025 10:54 AM, the surveyor reviewed the hybrid medical record of Resident #220, which revealed the following: A review of the AR reflected that Resident #220 was admitted with diagnoses that included, but were not limited to, ESRD. A review of the annual Minimum Data Set (A/MDS), dated [DATE], indicated that the facility assessed the residents' cognitive status using a BIMS score of 15 out of 15, which indicated that the resident had intact cognition. A review of the OSR with a start date on 12/17/24 revealed an order of dialysis at [facility name redacted] every Monday, Wednesday, and Friday at 6:00 AM, pick up at 5:00 AM. A review of the HD form included documentation from the HD clinic nurse and post-dialysis (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	information and assessment written by the facility nurse upon the resident's return to the facility, but does not contain an assessment section for pre-dialysis assessment by the facility nurse. A review of June and July 2025 electronic Progress Notes (ePN) shows no consistency in pre-dialysis nursing assessments. On 07/28/2025 at 10:47 AM, the LPN/Unit Manager (LPN/UM) stated that assessing the resident before they go to dialysis is essential. She added that she is aware that some nurses do not evaluate and document the resident before leaving for the dialysis center. On 7/30/2025 at 12:07 PM, the survey team met with the Licensed Nursing Home Administration (LNHA), [NAME] President of Clinical Services (VPCS), Regional Director of Nursing (RDON), and [NAME] President of Operations (VPO) regarding the above concern, but did not provide further information. A review of the facility policy titled Dialysis Management (Hemodialysis) with the last review date on 3/2025 revealed under Procedure: If dialysis is provided at off-site Dialysis Center: 1. Assure physician order includes: Medication administration times adjusted on dialysis treatment days. The facility policy does not include a pre-dialysis assessment procedure. NJAC 8:39-11.2(b), 27.1(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews, record review, and review of other facility documents, it was determined that the facility failed to provide pharmaceutical services in accordance with professional standards to ensure a.) quality control testing (calibration) was conducted for the blood glucose (bg) monitors, simultaneously used for residents, observed on two (2) of four (4) medication carts inspected, and identified for 7 of 7 medication carts; b.) timely receipt of medication (Sitagliptin, generic for Januvia a medication used to lower high blood sugar) for administration, and prevent borrowing from another resident's supply for one (1) of 8 residents observed during the medication administration.The evidence was as follows:1. On 7/30/25 at 9:17 AM, in the presence of the Licensed Practical Nurse (LPN #1) the surveyor began the inspection of medication cart #1 on the Third floor and observed two (2) bg monitors (glucometers). LPN #1 stated she disinfected the glucometer after she measured the amount of glucose (sugar) in a blood sample of a resident. The glucometers required drying time after disinfection, and while one glucometer was drying, she used the other glucometer to test the next resident's blood sugar. A review of the Third floor bg monitor (glucometer) control record reflected only one(1) glucometer was calibrated daily from 7/1/25-7/30/25. At that time, LPN #1 stated that the 11:00 AM – 7:00 PM shift nurse checked and calibrated the glucometers and was also unable to identify which glucometer was calibrated for accuracy. LPN #1 stated she was not responsible and did not calibrate the glucometer on her shift. At that time, the surveyor, and the Registered Nurse/Unit Manager (RN/UM) reviewed the glucometer control record together. The RN/UM #1 confirmed and acknowledged the record reflected only 1 glucometer was calibrated, checked for functionality and accuracy. A review of the Third floor's glucometer control record from May 2025 to July 2025 on the third floor reflected only one glucometer was calibrated, checked for functionality and accuracy. 2.) On 7/30/25 at 9:43 AM, in the presence of the Licensed Practical Nurse (LPN #2) the surveyor began the inspection of medication cart #1 on the Fourth floor and observed two (2) glucometers. A review of the Fourth-floor glucometer control record reflected only one (1) glucometer was calibrated daily from 7/1/25-7/30/25. At that time, LPN #1 stated that the 11:00 AM – 7:00 PM shift nurse checked and calibrated the glucometers and was also unable to identify which glucometer was calibrated for accuracy. LPN #1 stated she was not responsible and did not calibrate the glucometer on her shift. At that time, LPN #2 stated she used both glucometers, disinfected one (1) after each use, let the glucometer dry after disinfection and switched to the other glucometer, in-between residents. At that time, LPN #2 stated that the 11:00 AM – 7:00 PM shift nurse checked and calibrated the glucometers and was also unable to identify which glucometer was calibrated for accuracy. LPN #1 stated she was not responsible and did not calibrate the glucometer on her shift. On 7/30/25 at 9:43 AM, the surveyor and the RN/UM #2 reviewed the glucometer control record (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	together. The RN/UM #1 confirmed and acknowledged the record reflected only 1 glucometer was calibrated, checked for functionality and accuracy. A review of the Fourth floor's glucometer control record from May 2025 to July 2025 on the third floor reflected only one glucometer was calibrated, checked for functionality and accuracy. Further review of the July 2025 glucometer control record for the 5th, 6th, 7th, 8th and 9th floor reflected only one (1) glucometer was calibrated, checked for functionality and accuracy. On 7/30/25 at 12:19 PM, in the presence of the survey team, the [NAME] President of Operation (VPO), the [NAME] President of Clinical Operations (VPCO), the Regional Director of Nursing (RDON) and the Licensed Nursing Home Administrator (LNHA), the surveyor discussed the concerned that only 1 of 2 glucometers were calibrated, checked for functionality and accuracy. The VPCO stated she would conduct an investigation. On 7/31/25 at 10:11 AM, during a meeting with the survey team, the VPO, the VPCO, and the LNHA, the RDON confirmed there were two (2) glucometers in the cart and the 11:00 PM to 7:00 PM nurse checked only the primary glucometer and not the secondary. The RDON stated that the policy was revised to ensure both glucometers were calibrated and checked for functionality. A review of the provided facility policy Control Solution Testing for Blood Glucose Monitor dated/reviewed on 7/29/25, included that to ensure accuracy and reliability of the blood glucose results obtained from the (brand redacted) bg monitoring system, control solution testing would be performed in accordance with manufacturer's instructions and quality assurance protocols. 3. On 7/29/25 at 8:47 AM, the surveyor, while observing the medication pass (med-pass), observed the licensed practical nurse (LPN) assigned to the 9th floor medication cart prepare and administer medications for Resident #131. The surveyor observed that the LPN could not locate the medication sitagliptin 50mg, a medication used help control blood sugar levels in diabetes. The surveyor observed the LPN locate the same medication that was dispensed and labeled for another resident. The surveyor asked the LPN what the usual procedure and policy for missing medications was. The LPN stated that they would search for the medication to see if another resident was taking the same thing and borrow theirs. The surveyor observed the LPN administer all due medications as well as the sitagliptin that was from another resident's stock. The surveyor concluded the med-pass observation . The surveyor reviewed the electronic medical record (EMR) for Resident #131 which revealed the following: An admission record (AR), a document that includes pertinent resident information such as admission dates and diagnoses, which reflected that the resident had diagnoses that included but were not limited to hypertension (high blood pressure) and major depressive disorder (a mood disorder expressed as extended periods of sadness). A review of the resident's Comprehensive Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, with an assessment reference date of 5/20/25, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #131 scored a 6 out of 15, which indicated the resident had severe cognitive impairment. Part N of the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS reflected that the resident was receiving a medication classified as a hypoglycemic, sitagliptin is classified as a hypoglycemic. The surveyor reviewed Resident #131's electronic medication administration record (eMAR), a document that shows the resident medication orders, when they are schedules and who administered. The eMAR reflected that the resident had an order for sitagliptin 50mg, scheduled at 9:00 AM and was administered the medication on 7/29/25. The surveyor reviewed an Order Audit Report (OAR) and an Order Summary Report (OSR), each of which reflected that the resident had a current active physician's order for sitagliptin 50mg. On 7/29/25 at 9:15 AM, the Regional Director of Nursing, informed the surveyor that the LPN on the 9th floor wished to speak with him. At 9:41AM on the same day, the surveyor interviewed the LPN previously observed during the med-pass. The LPN stated that they found the medication, sitagliptin, for Resident #131 and showed the medication to the surveyor. The LPN also stated that the facility policy is not to borrow medications if they can't be found and to get them from the facility backup supply. On 7/29/2025 at 12:49 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Clinical Services (VPCS) and the [NAME] President of Operations (VPO) to discuss concerns. The surveyor informed the facility of the concern with borrowing medications from other residents. The VPCS responded that the policy is never to borrow and to check the facility back up supply and the LPN who did the borrowing was re-educated. On 7/29/25 at 1:05 PM, the surveyor interviewed the facility Consultant Pharmacist (CP) by phone. The surveyor asked the CP what the nurses should do if a medication is not available. The CP stated that nurses should check if the medications is available in the facility backup. If it is not there, then the resident's physician should be called for instructions. The surveyor asked if the staff should borrow meds from other residents. The CP stated no, medications should never be borrowed from any other resident. On 7/30/2025 at 12:09 PM the survey team met with the LNHA, VPCS, RDON, and VPO to discuss concerns and get responses. The RDON provided copies of attendance for education given to nurses regarding missing medications and an individual investigation for the nurse that was witnessed borrowing medications.The facility did not provide any further pertinent information. The surveyor reviewed the facility provided policy titled Medication Administration dated revised 9/2024. The policy reflected, under Purpose: Right resident/patient. The policy did not reflect any other information related to missing medications. NJAC 8:39-29.2(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, it was determined that the facility failed to accurately code the Minimum Data Set (MDS, an assessment tool used to facilitate the management of care), in accordance with federal guidelines, for 2 of 35 residents (Resident #220 and #274), who were reviewed for accuracy for MDS coding.This deficient practice was evidenced by the following: 1. On 07/28/25 at 10:45 AM, the surveyor observed Resident #220 in bed, awake, alert, who stated that they came back from dialysis this morning and have been attending dialysis (treatment used when the kidneys fail to function correctly) for more than five years now. On 07/28/25 10:54 AM, the surveyor reviewed the hybrid medical record (paper and electronic) of Resident #220, which revealed the following: A review of the admission Record (AR, an admission summary) reflected that Resident #220 was admitted with diagnoses that included, but were not limited to, end-stage renal disease (ESRD, the kidneys can no longer function). A review of the annual Minimum Data Set (A/MDS), (an assessment tool used to facilitate the management of care), dated 6/16/25, indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated that the resident had intact cognition. Further review of the A/MDS in Section O – Special Treatments, Procedures, and Programs stated Dialysis while a resident – No. A review of the Order Summary Report (OSR) with a start date on 12/17/24 revealed an order of dialysis at [facility name redacted] every Monday, Wednesday, and Friday at 6:00 AM, pick up at 5:00 AM. A review of the Care Plan Report with an initiated date of 6/13/2018, with the focus on at-risk for complications due to hemodialysis. On 07/28/25 at 10:47 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM), who confirmed that the resident goes to the dialysis center three times a week. On 07/29/25 at 11:16 AM, the surveyor interviewed the MDS Coordinator/Registered Nurse (MDSC/RN#1), who stated that the A/MDS assessment was miscoded by the MDSC/RN #2, who was on vacation at the time. The MDSC/RN #1 added that the dialysis should be coded at the annual assessment because the resident continues to receive dialysis treatment. 2. The surveyor reviewed Resident # 274's records. The resident was discharged from the facility, and according to the Discharge Return Not Anticipated MDS, an assessment tool used to facilitate the management of care, dated 5/1/25, the resident was assessed as having an unplanned discharge. A review of Resident # 274's progress notes dated 5/1/25 revealed the resident was discharged home with family. Review of progress notes upon admission on [DATE] and throughout the resident's stay, there were several notes that indicated that the resident had discharge planning in place. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/29/2025 at 11:16 AM, the surveyor interviewed the MDSC/RN#1, who stated that the discharge MDS should have been coded to indicate that the resident had a planned discharge. On 7/30/2025 at 12:07 PM, the survey team met with the Licensed Nursing Home Administration (LNHA), [NAME] President of Clinical Services (VPCS), Regional Director of Nursing (RDON), and [NAME] President of Operations (VPO) regarding the above concern, but did not provide further information. NJAC 8:39-33.2 (d)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review it was determined the facility failed to follow a physician's order for an insulin medication and acceptable professional standards of practice for 1 of 35 residents reviewed. This deficient practice is evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, 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.Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 7/29/2025 at 11:28 AM, the surveyor reviewed the electronic medical records (EMR) of Resident #71.The admission Record (a summary of important information about the resident) revealed that Resident #71 had diagnoses that included but were not limited to, type 2 diabetes mellitus (DM2).A comprehensive Minimum Data Set (MDS) assessment, a tool used to facilitate management of care, dated 7/17/2025, indicated the facility assessed the resident's cognition using a Brief Interview Mental Status (BIMS) test. Resident #71 scored a 7 out of 15, which indicated the resident had severe cognitive impairment. Section N (for medications) indicated the resident received insulin injections. A physician's order dated 7/12/2025 revealed for Humalog injection solution, inject subcutaneously before meals and at bedtime for DM2 9PM half dose insulin. The order was scheduled to be administered at 7:30AM, 11 AM, 4 PM, and 9PM. A review of the July 2025 Medication Administration Record (MAR) revealed the following for the Humalog injection insulin entry:-The order entry specified, .Inject as per sliding scale: if 151-200= 2 unit; 201-250= 4 unit; 251-300= 6 unit; 301-350= 8 unit; 351-400=10 unit. call MD < [less than] 60 or > [greater than] 400.subcutaneously before meals and at bedtime for DM2 9PM half dose insulin. - On 7/12/2025 at 9PM, it was documented the resident's blood sugar results was 158 and 2 units were administered to the resident.-On 7/13/2025 at 9PM, it was documented the resident's blood sugar results was 213 and 4 units were administered to the resident. - On 7/28/2025 at 9PM, it was documented the resident's blood sugar results was 203 and 4 units were administered to the resident.On 7/30/2025 at 10:11 AM, the surveyor interviewed a Registered Nurse Unit Manager (RN/UM) about Resident #71's insulin order indicating 9 PM half dose insulin. The RN/UM stated that it meant for the 9PM dose, the insulin to be given to resident should be half the insulin dose indicated by the sliding scale. The surveyor reviewed the physician's order and the MAR with the RN/UM. The RN/UM stated that there should have been a separate order entered for the 9PM dose administration to specify the half dose insulin sliding scale to be followed. The RN/UM acknowledged the order should have been clarified by the nurses and that she would clarify the order. On 7/30/2025 at 11:17 AM, the surveyor informed the Regional Director of Nursing (RDON) and the [NAME] President of Clinical Services (VPCS) of the concern regarding the insulin order for Resident #71. The RDON and the VPCS stated they would review and follow up with the RN/UM. On 7/30/2025 at 12:09 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA), the [NAME] President of Operations (VPO), the RDON, and the VPCS of the concern for Resident #71's insulin order. The RDON and VPCS stated that the order was clarified by the RN/UM and provided the surveyor a copy of the new order entry. The surveyor requested the facility's medication administration policy, and any other policy related to insulin administration.On 7/30/2025 at 12:31 PM, the surveyor interviewed the Consultant Pharmacist (CP) over the phone about the concern regarding Resident's #71 insulin order (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and no recommendations were noted for the resident's medication regimen review (MRR) dated 7/12/25. On 7/31/2025 at 8:59 AM, the CP called back and informed the surveyor that the CP had missed the 9PM half dose insulin comment on the order during the MRR. The CP further explained that it was not a typical insulin order.On 7/31/2025 at 10:11 AM, the LNHA, the VPO, the RDON, and the VPCS met with the survey team. The RDON stated the insulin order had been clarified for Resident #71, the facility audited insulin orders for other residents, provided education to nursing staff, and one on one in-service education was provided to the nurses who did not follow the physician's order when administering the 9PM insulin dose to Resident #71. There was no additional response provided by the facility's management. The surveyor reviewed the facility provided policy titled, Medication Administration, with a last revised date of September 2024. Under Purpose revealed: To administer the following.Right medication.Right dose. Right documentation.Right timeUnder Procedure of the policy revealed: .9. Read the Medication Administration Record (MAR) for the ordered medication, dose, dosage form, route, and time.NJAC 8:39-11.2 (b); 29.2(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315112	A. Building B. Wing	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hudsonview Health Care Center	9020 Wall Street North Bergen, NJ 07047

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store Controlled Substance medications (CDS) securely per regulations and standards of practice. This deficient practice was identified in one (1) of four (4) medication carts (med carts) observed in the facility.This deficient practice was evidenced by the following:Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist.On 7/30/2025 at 10:08 AM the surveyor began to inspect selected medication (med) storage areas in the facility. The surveyor observed the following:On the facility 6th floor, the surveyor, in the presence of the Licensed Practical Nurse (LPN) assigned to the med cart, accessed the med cart. The surveyor opened the drawer where the CDS are stored. The surveyor observed that the lock box containing the CDS was not closed or locked and was readily opened by the surveyor without a key. The surveyor asked the LPN if the CDS box should be locked. The LPN stated, yes it should be locked, but the medications inside keep it from closing easily and sometimes you must shut it very hard.The surveyor concluded the inspection of the med cart.On 7/30/2025 at 12:09 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), [NAME] President of Clinical Services (VPCS), Regional Director of Nursing (RDON), and [NAME] President of Operations (VPO) to discuss concerns. The surveyor discussed the concern with the CDS storage box not being locked.On 7/30/25 at 2:00 PM, the surveyor interviewed the facility Consultant Pharmacist (CP) by phone. The surveyor asked the CP what the correct way was to store CDS in the med cart. The CP stated that CDS should be stored behind two (2) separate locks, in its own compartment. The med cart should be locked and the CDS box should be locked. The surveyor informed the CP about the concern with the 6th floor med cart lock box that was accessible to the surveyor without a key and was not closing properly.On 7/31/2025 at 10:11 AM, the survey team met with the LNHA, VPCS, RDON, and VPO for responses to concerns. The RDON stated that the CDS lock box was fixed by re-organizing the way the medications fit inside so the top closes easily. The VPCS stated that staff education on storage of CDS was also performed.The facility did not provide any further pertinent information.The surveyor reviewed the facility policy titled Medication Storage with a last reviewed date of 9/2024. The policy reflected, under line 1 Narcotics and Controlled Substances: Schedule II drugs. are stored under double-lock and key.The surveyor reviewed the facility policy titled Medication Administration with a revision date of 9/2024. The policy reflected, under Procedure, line 27 Assure controlled substances are double locked. NJAC 8:39-29.7 (c)