STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattanview Ctr for Rehabilitation and Healthcar	3200 Hudson Avenue Union City, NJ 07087

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 45449 NJ #170244 Based on observation, interview, and review of medical records, and other facility documentation, it was determined that the facility failed to timely and thoroughly investigate allegations of abuse for one (1) of two (2) residents (Resident #46) reviewed for abuse. This deficient practice was evidenced by the following: On 5/07/24 at 10:19 AM, the surveyor observed the resident had a visitor who was discussing leaving the facility for a few minutes. The surveyor observed the resident lying in bed, awake, head of the bed was elevated, and was communicative. At 10:53 AM, the resident informed the surveyor that a nurse [name redacted] threw coffee at him/her. The resident narrated the following: She was snotty. The Resident recalled the nurse said to him/her I'm going to whip your ass. I pushed the table towards her then she threw coffee at my face, I called the police. The surveyor reviewed the medical records of Resident #46. According to the Admission Record (or face sheet; an admission summary) reflected that the resident had been admitted with diagnoses which included type 2 diabetes mellitus (DM; high blood sugar) without complications, and bipolar disorder (a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration). Resident #46' s most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 4/13/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident cognition was intact. Additionally, the qMDS revealed that the resident had no indicators of psychosis, had no hallucinations, was not delusional and had no behaviors relating to rejection of care. Review of Resident 46's Care Plan (CP), initiated on 3/13/22 and most recently reviewed on 5/15/24, included the resident had negative behaviors and poor judgment related to disorganized thinking, and confabulating (fabricating) stories. (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the reportable event record/report (FRE; Facility Reported Event) reflected that it was called in by the facility on 5/10/23 at 4:35 PM to the state agency. Under today's date reflected 11/18/23, and an event date of 11/16/23 at 8:00 PM. The incident was reported as an allegation of staff-to-resident abuse. The event was described as follows: Resident #46 reported that a Nurse threw coffee at him/her. The report indicated that there were no planned interventions prior to the event. After the event, Resident #46 was assessed, was noted with no visible injury, emotional support was provided, care plan was updated, staff were interviewed, the resident was encouraged to express feeling and concerns to appropriate staff, physician, family, and ombudsman were made aware. The nurse was immediately removed. Review of the nursing assignment sheets reflected there were two (2) Licensed Practical Nurse (LPN) and four (4) Certified Nursing Assistant (CNA) and 1 Registered Nurse/Supervisor assigned to Resident #46's floor. Review of the undated/unsigned Investigative Summary (IS) included that the investigation involved medical records, care plan, staff interviews and behavior monitoring. The conclusion reflected that the resident became frustrated when the nurse tried to assist with retrieving and paying for food at the lobby. The report reflected resident had behaviors of verbal abuse towards staff, at times. The resident assessed by the nursing staff and was found to not have injuries, and had no complaint of pain, the body check did not reveal redness. Attached to the IS was a written statement dated 11/16/23, by CNA #1 assigned to the resident revealed that the CNA #1 did not see the incident, and that there were no reports of the incidents made to her by the resident. Another attachment to the IS report was a written statement dated 11/16/23, by CNA #2 that reflected she did not see anything or hear anything bad about the nurse. The third attachment included was an undated typed statement from the Registered Nurse/Supervisor (RN/S) that showed that at around 8:00 PM the resident called the police after throwing coffee on the Licensed Practical Nurse (LPN #1) whose last name was not included in the statement. The LPN went to the front desk to get the food and was told money was required. The resident cursed at the nurse and threw coffee on the nurse. The nurse was observed to have coffee all over her. The [town redacted] Police Department (PD) interviewed the resident and took a full report. The [town redacted] PD report, the Resident statement, the alleged LPN #1 perpetrator, LPN #2, CNA #3, and CNA #4's statements were not included in the IS report. Upon further review, the IS report did not identify the full name of the alleged LPN perpetrator, the status of the LPN after investigation in relation to Resident #46, LPN certification, license number, status, date of expiration, criminal background, reference check, most recent education on behavioral health, and abuse prevention. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/09/24 at 11:57 AM, in the presence of the survey team, the Registered Nurse [NAME] President of Clinical Operations (RNVPoCO), VP of Operations (VPoO), Licensed Nursing Home Administrator (LNHA), and the Director of Nursing (DON), the surveyor discussed the concern regarding the issues on the time of the facility reported event, the missing statement of the resident and alleged LPN #1. The missing perpetrator's full name, license information, reference, criminal background check as part of the investigation that was conducted by the facility. On 5/14/27 at 11:22 AM, in the presence of the survey team, the RNVPoCO, the VPoO, the LNHA, and the Infection Preventionist/Registered Nurse (IP/RN), the DON stated that the facility called date on 5/10/23 at 4:35 PM must have been a typographical error. At that time, the DON stated that she did not think she had to include the alleged LPN #1's name in the report. The DON acknowledged it should have been included within the submission. At that time, the DON stated that she had not conducted a review of the background check for LPN #1 because they had concluded the allegation was unsubstantiated. At that time, the VPoO stated that LPN #1 was an agency nurse and education was provided but could not state why the education for behavior and abuse prevention was not maintained on the file. At that time, the DON stated that a statement from LPN #1 was obtained but could not locate the document. A review of the provided policy and procedure: Abuse Prevention dated/initiated May 2008 included the following: Reporting and Investigation Protocols -All phases of the investigation will be kept confidential in accordance with the facilities policy governing and confidentiality of medical records. Notices to regulatory agencies will include at the minimum: The name(s) of any person(s) involved in the alleged incident. -The person conducting the investigation will: Interview all witnesses and staff in the immediate area. -Witness reports will be in writing. Witness will be required to sign and date such reports. All such reports will be attached to the Abuse Investigation Report. -If a behavioral symptom begins suddenly or gets worse quickly, the following guidelines should be implemented at the time that the behavior occurs: No further information was provided. NJAC-8.39-4.1(a)5, 13.4(c), 27.1 (a)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885 Based on interview, record review and review of other pertinent facility documents, it was determined that the facility failed to provide the resident and/or the resident's representative written notification of the reason for transfer to the hospital for two (2) of two (2) resident's (Resident #93 and #97) reviewed for hospitalization . This deficient practice was evidenced by the following: 1. A review of Resident #93's electronic medical record included the following: Resident #93's discharge assessment-return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, dated 4/08/24 and 5/01/24, reflected that the resident was transferred to the hospital. A review of Resident #93's hybrid (a combination of paper, scanned, and computer-generated records) medical record did not include a written notification of the reason for transfer to the resident or resident representative for each transfer to the hospital. 2. A review of Resident #97's closed medical record included the following: Resident #97's DRAMDS dated [DATE] and 4/26/24, reflected that the resident was transferred to the hospital. A review of Resident #97's hybrid medical record did not include a written notification of the reason for transfer to the resident or resident representative for each transfer to the hospital. On 5/08/24 at 12:55 PM, the surveyor interviewed the Director of Social Services (DoSS) regarding written notification of the reason for transfer. The DoSS stated that the facility did not send written notification to the resident or resident representative when the resident was transferred to the hospital. She added that the facility did send out a notice to the ombudsman that was faxed every month. On 5/09/24 at 12:22 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), [NAME] President of Operations (VPoO), Registered Nurse VP of Clinical Operations (RNVPoCO) the concern that the residents and/or their representatives did not have written notification of the reason they were transferred to the hospital. On 5/14/24 at 11:51 AM, in the presence of the survey team, DON, Infection Preventionist/Registered Nurse (IP/RN), VPoO and RNVPoCO, the LNHA stated that he educated the DoSS in regard to the written notification and that the residents should have had the written notification for each transfer to the hospital. A review of the facility provided policy titled, Transfer/Discharge Notification with a last reviewed date of 02-2024, included the following: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protocol 1. Transfers and discharges include the movement of a resident/patient to a bed outside of the certified section whether that bed is in the same physical plant or not . 3. Transfers and discharges will be conducted according to State and Federal regulations. Procedure 1. Provide the resident/patient with the Bed Hold and In-House Transfer Policy form as follows: At the time of admission At the time of transfer . 4. Inform the resident/patient, legal representative, and family member of the right of appeal. N.J.A.C. 8:39-4.1(a)31,32

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39885 Based on interview, review of the medical record and review of other pertinent facility documentation, it was determined that the facility failed to provide the resident or resident representative written notification of the facility's bed hold policy prior to transfer to the hospital for two (2) of two (2) resident's (Resident #93 and #97) reviewed for hospitalization s. This deficient practice is evidenced by the following: 1. A review of Resident #93's electronic medical record included the following: Resident #93's discharge assessment-return anticipated Minimum Data Set's (DRAMDS), an assessment tool used to facilitate the management of care, dated 4/08/24 and 5/01/24, reflected that the resident was transferred to the hospital. A review of Resident #93's hybrid (a combination of paper, scanned, and computer-generated records) medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative prior to each transfer to the hospital. 2. A review of Resident #97's closed medical record included the following: Resident #97's DRAMDS dated [DATE] and 4/26/24, reflected that the resident was transferred to the hospital. A review of Resident #97's hybrid medical record did not include a written notification of the facility's bed hold policy to the resident or resident representative prior to each transfer to the hospital. On 5/08/24 at 01:05 PM, the surveyor interviewed the Admissions Director (AD) regarding bed hold policy notification. The AD stated that residents received the bed hold policy on admission and that she did not send out a written notification at time of transfer to the hospital. She added that the residents know that they have a ten day hold and that the facility always accepted them back even if it was past ten days. On 5/09/24 at 12:22 PM, in the presence of the survey team, the surveyor notified the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), [NAME] President of Operations (VPoO) and Registered Nurse VP of Clinical Operations (RNVPoCO) the concern that the residents and/or their representatives did not have written notification of the bed hold policy when they were transferred to the hospital. On 5/14/24 at 11:51 AM, in the presence of the survey team, DON, Infection Preventionist/Registered Nurse (IP/RN), VPoO and RNVPoCO, the LNHA stated that he educated the AD in regard to the written notification of the bed hold policy and that the residents should have had the written notification for each transfer to the hospital. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided policy titled, Bed Hold Notice Upon Transfer with a last reviewed date of 02-2024, included the following: Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy A review of the facility provided policy titled, Bed Hold and In-House Transfer with a last reviewed date of 02-2024, included the following: Protocol 1. A written notification of bed hold and in-house transfer policy form will be given to the resident/patient and his/her family member/legal representative upon admission. 2. A written notification (signed and dated by the resident/patient and family member) must be given to the resident/patient and family member each time of transfer for hospitalization or therapeutic leave. 3. The bed hold and in-house transfer policy form to be completed and issued as instructed on the document . A review of the facility provided policy titled, Transfer/Discharge Notification with a last reviewed date of 02-2024, included the following: Protocol 1. Transfers and discharges include the movement of a resident/patient to a bed outside of the certified section whether that bed is in the same physical plant or not . 3. Transfers and discharges will be conducted according to State and Federal regulations. Procedure 1. Provide the resident/patient with the Bed Hold and In-House Transfer Policy form as follows: At the time of admission At the time of transfer . 4. Inform the resident/patient, legal representative, and family member of the right of appeal. N.J.A.C. 8:39-5.1 (a); 5.2 (a)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 38327 Based on the interview and review of pertinent facility documents, it was determined that the facility failed to complete the discharge Minimum Data Set (MDS) assessment, an assessment tool, as required for one (1) of one (1) system selected for the resident with an MDS record over 120 days reviewed (Resident #107). This deficient practice was evidenced by the following: On 5/08/24 at 12:13 PM, the surveyor reviewed the system-generated Resident Assessment Task and showed that Resident # 107 was identified as the resident's MDS record over 120 days old. The surveyor reviewed the medical records of Resident #107 as follows: According to the Admission Record (admission summary), Resident #107 was admitted to the facility with a diagnosis that included but was not limited to muscle wasting and atrophy (a clinical sign of lack of nourishment, disuse) not elsewhere classified, multiple sites, nonrheumatic aortic valve insufficiency (when the aortic valve of the heart leaks and causes blood to flow in the wrong direction), essential hypertension (abnormally high blood pressure that's not the result of a medical condition), and type 2 diabetes mellitus with hyperglycemia (diagnosed when fasting blood sugar exceeds the normal). On 5/14/24 at 8:41 AM, the surveyor interviewed the MDS Coordinator Licensed Practical Nurse (MDSC/LPN) regarding the MDS in the presence of the Director of Nursing (DON). The MDSC/LPN stated that she was not sure when the discharge return not anticipated (DRNA) MDS should be transmitted after completing the assessment. At that same time, the surveyor notified the MDSC/LPN of the concern that Resident #107's DRNA MDS was completed and transmitted on 5/08/24 which was 99 days after completing the assessment. The MDSC/LPN stated that she missed it which was why the DRNA MDS was completed and transmitted late. In addition, the MDSC/LPN acknowledged that the DRNA MDS was not within 14 days after a facility completes a resident's assessment. Furthermore, the MDSC/LPN further stated that the facility followed the RAI (Resident Assessment Instrument, helps nursing home staff gather definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan) manual for MDS and there was no other policy on how to do MDS. On 5/14/24 at 11:22 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Infection Preventionist/Registered Nurse (IP/RN), [NAME] President of Operations (VPoO), and the Registered Nurse VP of Clinical Operations (RNVPoCo). The surveyor notified the facility management of the above findings. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	On 5/16/24 at 10:42 AM, the MDSC/LPN in the presence of the MDSC/Registered Nurse provided a copy of the MDS 3.0 Missing OBRA (Omnibus Budget Reconciliation Act-required discharge assessments that include DRNA that must be completed) Assessment Report for the following dates: 11/20/23 12/21/23 01/09/24 02/06/24 3/11/24 On that same date and time, the surveyor asked the facility management, if the facility was doing monthly ran of missing reports, why there was no report for April 2024. The MDSC/LPN stated that she was unable to find the copy for April 2024 that she ran the report for missing MDS. She further stated that otherwise there was no excuse that MDS was late. According to the CMS' (Centers for Medicare & Medicaid Services) RAI Version 3.0 Manual dated October 2019 that was provided by the MDSC/LPN regarding the transmittal requirements, it included that, 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 DRNA. A review of the facility's RAI Process Policy that was provided by the DON with the last reviewed date of 02/2024 included the purpose to ensure that the MDS for each resident is completed accurately and timely in accordance with State and Federal regulations. A review of the facility's Completion of MDS Policy that was provided by the DON with the last reviewed date of 02/2024 did not include and specify when to complete and transmit the MDS. On 5/17/24 at 10:51 AM, the surveyors met with the LNHA, DON, RNVPoCO, VPoO, IP/RN, and VP Clinical Compliance for Exit Conference and the facility management did not provide additional information. NJAC 8:39- 11.1

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45209 Based on interview, review of medical records, and other facility documentation, it was determined that the facility failed to adhere to acceptable standards of nursing practice in regards to the documentation of a resident's expiration. This deficient practice was identified for one (1) of three (3) residents (Resident #126) reviewed for closed records and 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 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 regimes 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 state: 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. The surveyor reviewed the medical record for Resident #126: A review of the Admission Record face sheet (an admission summary) reflected that Resident #126 was admitted to the facility with diagnosis that included, but not limited to, malignant neoplasm (cancer) of bladder and chronic kidney disease (longstanding disease of the kidneys leading to renal failure). A review of the electronic medical record (eMR) Nursing Progress Notes included a note dated [DATE] at 6:18 PM that indicated, [4:50 PM] Spoke with [.] regarding ETA of pick up. Will call back to inform. Body post mortem care rendered. Tag placed on Right big toe, and lower body wrapping. [5:39 PM .] called to notify of pick up window 45 min to one hour. responsible party [.] notified of ETA (estimated time of arrival) of pick up. Family will pick up patient belongings. Belongings gathered for family. [5:55 PM] Resident picked up by [.] body release form filled and signed, placed in chart. responsible party [.] notified of body being picked up. Pending pick up of belongings. There was no documentation of a change in the resident's clinical condition, including patient condition, vital signs (clinical measurements, specifically pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a resident's essential body functions), along with time of death, physician notification, and family notification. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:03 PM, the surveyor interviewed the Director of Nursing (DON), in the presence of the Licensed Home Nursing Administrator (LNHA), who confirmed that the required documentation for a resident's death included the time of death, change in condition assessment, physician notification, and family notification. The DON acknowledged that the resident's time of death was important information for the electronic death registration system. The DON further stated that all documentation should be entered as soon as it happens. At that same time, the DON confirmed that, the nurse documented the body pick up but not the time of death. When asked if there was further information that should have been documented the DON responded, the time the physician was made aware, if the family was at bedside, and change of condition. At the end of the interview, the DON inquired if the nurse could submit a late entry. On [DATE] at 10:06 AM, the surveyors met with the LNHA in the presence of the DON, Registered Nurse [NAME] President (VP) of Clinical Operations, and VP of Operations, the facility management acknowledged that, based on the electronic medical record, the resident's death could not be determined, who pronounced the death, and if the physician/family were made aware. A review of the facility's Nurse's Notes policy, last reviewed ,d+[DATE], included: .Nurse's notes upon expiration should include: date, time of death, physician notification, death pronouncement by physician or RN, family notification and visitation, disposition of eyeglasses, dentures, valuables, personal belongings, and medications. Name and location of mortician or funeral home, post-mortem care given to resident, religious rites performed, if applicable release of body . A review of the facility's Death of a Resident/Patient policy last reviewed ,d+[DATE], included: Assess the resident/patient for vital signs: apical pulse; respirations; blood pressure .Call the physician and report your assessment of absence of vitals signs. Write the pronouncement and release as a telephone order .Notify the resident/patient's family, guardian, and/or representative .Document the following in the nurse's notes: time of absence of vital signs as determined; time and name of physician notified; time and name of family member notified; name of designated funeral home and time notified; name of the funeral home representative and time body released; status of deceased resident/patient personal possessions and what was sent with the body (i.e.: glasses, dentures, etc. A review of the facility's undated Job Description and Performance Standards included: to assess resident treatment needs and take appropriate action and to maintain resident's medical records. NJAC 8:,d+[DATE].2(b)

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NAME OF PROVIDER OR SUPPLIER Manhattanview Ctr for Rehabilitation and Healthcar		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 Hudson Avenue Union City, NJ 07087	

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 38327 Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to post the accurate Nursing Home Resident Care Staffing Report daily. This failure could affect the knowledge of the availability of staff to care for the 120 residents, their family members, or their representatives. This deficient practice was evidenced by the following: On 5/07/24 at 8:35 AM, the surveyors entered the facility (on a Tuesday) and observed that the Nursing Home Resident Care Staffing Report (NHRCSR) posted in the front lobby was dated 5/02/24 (Thursday). The census (total number of residents) that was posted on 5/02/24 NHRCSR was 120. A review of the facility submitted Nurse Staffing Report for the week of 4/28/24 to 5/04/24 that was provided by the Director of Nursing (DON) showed that the census on 5/02/24 was 119. Further review of the above revealed that the census posted on 5/02/24 NHRCSR in the front lobby did not match the submitted Nurse Staffing Report. On 5/09/24 at 11:56 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), DON, Registered Nurse [NAME] President of Clinical Operations (RNVPoCO), and VP of Operations (VPoO). The surveyor notified the facility management of the findings regarding the inaccurate posting of the NHRCSR on 5/07/24. On 5/14/24 at 11:22 AM, the survey team met with the LNHA, DON, Infection Preventionist/Registered Nurse (IP/RN), VPoO, and RNVPoCO. The LNHA stated that the NHRCSR should be posted daily at 8 AM. The VPoO stated and clarified that the NHRCSR should be accurate, updated, and posted at the beginning of each shift. On 5/16/24 at 8:31 AM, the surveyor interviewed the Human Resource and Business Office Manager (HR/BOM). The HR/BOM informed the surveyor that she was responsible for posting the NHRCSR in the front lobby of the facility. The HR/BOM stated that she prepares the NHRCSR Monday through Friday and makes sure that it is posted before 8 AM. She further stated that she prepares the NHRCSR in advance for weekends and it is the responsibility of the weekend supervisor to correct if there will be changes in the census. She also stated that the NHRCSR should be updated at the beginning of each shift. On that same date and time, the surveyor notified the HR/BOM of the above findings and concerns. The HR/BOM had no response as to why the posted NHRCSR on 5/07/24 was not accurate. Later on, the HR/BOM stated that the posted NHRCSR should have been updated and accurate. A review of the facility's Nurse Staff Posting Information Policy with a reviewed date of 11/2023 that was provided by the LNHA included that it is the policy of the facility to have sufficient staff to provide nursing services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The nurse staffing information will contain the following information: facility name, the current date, the facility's current census, and the total number and actual hours worked by the RN, Licensed Practical Nurses, and Certified Nurse Aides. (continued on next page)

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	315465	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/17/24 at 10:51 AM, the surveyors met with the LNHA, DON, RNVPoCO, VPoO, IP/RN, and VP of Clinical Compliance for Exit Conference and the facility management did not provide additional information. N.J.A.C. 8:39-41.2 (a)(b)(c)(d)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 45449 Reference F-756 Based on observation, interview, record review, and review of other pertinent facility documentation it was determined that the facility failed to ensure a resident with history of post-traumatic stress disorder (PTSD) received appropriate treatment and services to attain the highest practicable mental and psychosocial well-being. This deficient practice was identified for one (1) of five (5) residents (Resident #80) reviewed for unnecessary medications and was evidenced by the following: Reference: 13:44G-3.3 PRACTICE AS A CSW; SCOPE c) A CSW shall not engage in clinical social work services. 13:44G-1.2 DEFINITIONS Clinical social work means the professional application of social work methods and values in the assessment and psychotherapeutic counseling of individuals, families, or psychotherapy group. On 5/07/24 at 11:05 AM, during the initial tour, the surveyor observed Resident #80 resting on the bed, in a fetal position with a monitoring device [for residents at risk of wandering] on the left ankle. The resident spoke [language redacted]. At that time, the house keeping staff (HK) translated for the resident. The resident stated he/she felt no discomfort from the monitoring device and wanted to rest. On 5/09/24 at 11:23 AM, during an interview with the surveyor, the Director of Social Services (DSS) stated she was a Certified Social Worker (CSW). The DSS stated her responsibilities included scheduling meetings for the residents, their family, and the Interdisciplinary team to discuss the patient centered care. On 5/13/24 at 10:19 AM, the surveyor entered the room, observed the resident lying in bed, and was not responsive to conversation conducted in [language redacted]. At that time, the surveyor also observed the Certified Nursing Assistant (CNA) standing across the room. At that time, the CNA stated he was assigned to watch the resident. The CNA stated he was a one (1) to one (1) assignment and could not describe the reason for the one-on-one surveillance. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/24 at 10:20 AM, Resident #80 and the CNA were observed walking the hallway into the dayroom where activities were being held. The surveyor reviewed the hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical records of Resident #80. According to the resident's Admission Record (AR, or face sheet, an admission summary) reflected that resident was a long-term care (LTC) resident at the facility and had diagnoses which included but were not limited to major depressive disorder, psychotic disorder (a mental disorder characterized by a disconnection from reality), anxiety disorder, mild cognitive impairment, and unspecified dementia. Further review of the above AR, PTSD was not listed. A review of Resident #80's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 02/28/24, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15, which indicated that Resident #80's cognition was moderately impaired. Further review of the qMDS section I-Active Diagnoses under Psychiatric/Mood Disorder reflected anxiety disorder, depression and psychotic disorder (other than schizophrenia). PTSD was not marked. A review of the Pre-Admission Screening and Resident Review (PASRR) level 1 Screen, a screening tool that must be completed for all applicants to a nursing facility (NF), prior to admission included the following: Under Section 2 - Mental Illness Screen: MDD [Major Depressive Disorder], Severe with Psychotic symptoms/PTSD. According to the PASRR Level 2 Determination Notification Form, it was determined that the resident had mental treatment needs that can be met in the NF. The following recommendation were made: 1. Psychiatric consult upon admission to Nursing Facility 2. Routine follow up visits with Primary Care Physician and Psychiatrist 3. Medication Monitoring 4. Supportive Counseling 5. Routine laboratory testing 6. Formulate and implement a behavioral modification plan to address any behavioral disturbances 7. provide education to client and family on mental illness and medication (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8. Develop a Crisis Intervention/Safety Plan with the client A review of Resident 80's Care Plan (CP; person centered plan) did not include a focus for PTSD. A review of the electronic Medical Record (eMR) under Miscellaneous did not reveal consultation with the Psychologist or Supportive counseling. A review of the Social Services Progress Notes (PN) did not reflect documentation that emotional counseling services was provided in relation to PTSD. A review of the electronic Medical Record under PN where the Consultant Pharmacist (CP) documented a brief note that a Report would be provided to the facility. The PN did not reveal a monthly Medication Regimen Review (MRR) for March 2024. The April 2024 reflected a late entry that was created on 5/09/24 by the CP. A review of the CP Report did not reflect an MRR for March and April 2024. A review of the initial Psychiatric Consult from the previous provider dated 11/29/21, did not reflect PTSD was addressed. A review of the initial and subsequent Psychiatric Consult with the new provider dated 01/16/24, 02/13/24 and 4/02/24 did not reflect that the provider identified, determined the underlying cause, developed, implemented approaches such as determining the target behaviors and non-pharmacological interventions to address the resident's PTSD. A review of the Monthly Psychotropic Summary (Behavior Monitoring Summary) for January 2024, February 2024, March 2024, April 2024 and the current May 2024, did not show identified triggers, associated intervention for PTSD. On 5/14/24 at 9:56 AM, during an interview with the surveyor, the Doctor of Nursing Practice (DNP)/Psychiatric Mental Health Nurse Practitioner (PHNP) informed the surveyor that the company she had worked for had taken over the facility for Psychiatric services less than a year ago. The DNP/PHNP stated she had conducted an initial evaluation of the resident on 01/16/24, and only had three total visits. At that time, the DNP/PHNP confirmed she had not addressed the PTSD on the resident's psychiatric evaluation even though it was identified as part of the Resident #80's chief complaint. At that time, the DNP/PHNP stated that the resident did not appear to need psychotherapy and acknowledged that ruling out the need was not documented on the three previously conducted visits. At that time, the surveyor had asked the DNP/PHNP if target behaviors and non-pharmacological interventions were part of the diagnosis and plan. The DNP/PHNP stated that it was nothing that she had placed on the note. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/24 at 12:13 PM, in the presence of the survey team, the Registered Nurse [NAME] President of Clinical Operations (RNVPoCO), the [NAME] president of Operations (VPoO), the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the Infection Preventionist/Registered Nurse (IP/RN), the surveyor discussed the concern regarding the failure to provide services that included development of an individualized care plan, monitor and provide ongoing assessment of Resident #80's behavior to address the resident's history of PTSD from admission. On 5/16/24 at 12:40 PM, in the presence of the survey team, the RNVPoCO, the VPoO, the LNHA, and the IP/RN, the DON stated, regarding Resident #80 and PTSD we should have looked at the diagnosis, we did not identify it. The DON also stated that Psych (Psychiatrist) did not evaluate and treat Resident #80 for PTSD. At that time, the DON acknowledged that the resident should have also been care planned for PTSD. On 5/16/24 at 02:35 PM, the DON had informed the surveyor that Resident #80 was scheduled to meet with the psychologist that afternoon. A review of the facility policy provided, Care Plan dated/revised 01/2024, included the following: Policy: It is the policy of [facility name redacted] that all residents admitted to the facility will have adequate person-centered care plans that provide for all their needs in a timely manner. Procedure: 1. Baseline Care Plans for all new admission will be initiated within 48 hours of admission 2. They will include goals, MD (Medical Doctor) orders, medications, treatments, dietary orders, therapy orders, social services and PASARR [PASRR] recommendations. 4. If PASARR [PASRR]recommends any special services for specialized rehabilitation services, it will be included in the care plan. If the facility disagrees with the findings of the PASSAR [PASRR] it will indicate its rationale in the residence medical record A review of the facility policy provided; Trauma Informed Care dated/reviewed 2/2024 included the following: Purpose: 3. The Level 1 PASARR Screen will be reviewed upon admission as well as upon any newly diagnosed mental illness and/or intellectual disability/ developmental disability. The recommendations from the PASARR Level 2 determination will assist in the completion of the resident's assessment, care planning and transition care. 10. Trauma specific interventions for a resident will be placed in their individualized person-centered care plan upon admission and assessment . 11. The facility will evaluate the progress of the trauma informed program by reviewing quarterly the changes in behavior of our residents who have been identified as having traumatic experiences during our multidisciplinary care plan and other 1-1 meeings. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	NJAC 8:39-27.1 (a), 28.1 (c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) to consistently maintain accurate reconciliation, accountability of dispensed, and administered controlled dangerous substance (narcotic medication) for Resident #16, b.) ensure expired narcotic medications were detected, removed, and disposed from active inventory which was stored within the electronic back-up machine (EBM). The deficient practice was identified for one (1) of one (1) of the EBM observed during medication storage inspection. The evidence was as follows: 1.) On [DATE] at 8:57 AM, during an interview with the surveyor, the Director of Nursing (DON) stated that she conducted the narcotic reconciliation (cycle counts) daily with a nurse supervisor or with the Infection Preventionist/Registered Nurse (IP/RN). The DON also stated she received a daily report of the narcotic inventory which detailed which the inventory on-hand, the nurse who removed the narcotic and for which resident. At that time, the surveyor requested for the daily transaction inventory report of the EBM. The surveyor reviewed the medical record for Resident #16. According to the resident's Admission Record (or face sheet, an admission summary) reflected that that resident was a long-term care (LTC) resident at the facility and had diagnoses which included but were not limited to heart failure, and chronic pain (long standing pain that persists). Resident #16's Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [DATE], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated that Resident #16's cognition was intact. On [DATE] at 10:46 AM, the DON informed the surveyor that the pharmacy provider was having issues with the report, and she had not received the daily report from the pharmacy [via electronic mail]. The facility did not keep a paper log of the EBM inventory. At that time, the DON stated that she did not work seven days a week and there were no tracking or reconciliation of the narcotic medications (meds) within the EBM on the weekend that she was off. On [DATE] at 11:03 AM, while waiting for the pharmacy provider inventory report, the DON stated that there were no super users (staff that can remove a narcotic med from the EBM without a witness) in the facility. On [DATE] at 12:25 PM, the surveyor and the DON reviewed the EBM report for Transactions by Employee from [DATE] to [DATE]. The report did not reflect a daily reconciliation of all the narcotic meds daily. At that time, the DON confirmed that the narcotics were not reconciled daily. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 01:11 PM, in the presence of the IP/RN and the DON, the surveyor reviewed another facility provided report; Transaction log by department (TLD). The report showed the inventory for the Morphine (narcotic pain med) 30 mg (milligram) on [DATE], was 13 tablets then on [DATE], the inventory on hand was seven (7) tablets, with no other transactions in between. Further review of the TLD did not reflect the witnesses' names when the narcotic meds were removed. At that time, in the presence of the DON and the IP/RN, the surveyor discussed the concerns regarding the missing witnesses name and the declining inventory count of the Morphine 15 mg tablets (tabs) without transactions in between. On [DATE] at 11:57 AM, in the presence of the survey team, the Registered Nurse [NAME] President of Clinical Operations (RNVPoCO), [NAME] President of Operations (VPoO), Licensed Nursing Home Administrator (LNHA), and the DON, the surveyor discussed the concern regarding the facility's failure to consistently maintain accurate reconciliation, accountability of dispensed, and administered narcotic meds. On [DATE] at 12:49 PM, the DON provided the surveyor a third report, the Controlled Substance by Container Report (CSCR). A review of the CSCR report reflected the witnesses' names, enumerated transaction by date/time with the declining inventory count of the Morphine 15 mg tabs from 13 to 7. Further review of the Morphine 15 mg tab CSCR reflected the following: -On [DATE] at 12:34 PM, the DON removed two (2) tabs, for Resident #16 with witnessed by LPN #1 -On [DATE] at 6:54 PM, the IP/RN removed two (2) tabs for Resident #16, witnessed by LPN #2 -On [DATE] at 8:35 AM, the DON removed (2) tabs for Resident #16, witnessed by LPN #3 -On [DATE] at 9:27 PM, the RN/Supervisor (RN/S) removed 2 tabs for Resident #16, without a witness -On [DATE] at 10:03 PM, the RN/S replaced 2 tabs back name into the EBM utilizing Resident #16's name, without a witness -On [DATE] at 10:15 AM, the RN/Unit Manager (RN/UM) removed two (2) tabs for Resident #16, witnessed by LPN #4 -On [DATE] at 9:49 PM, RN/S removed two (2) tabs for Resident #16 without a witness -On [DATE] at 9:09 AM, LPN #1 removed two (2) tabs for Resident #16 witnessed by IP/RN The CSCR revealed that the facility had a staff that did not require a witness to remove a narcotic med. A review of the Order Summary Report (OSR) for [DATE] reflected an order for Morphine 30 mg, give 1 tab by mouth every 12 hours for pain management. The OSR did not reveal an order for Morphine 15 mg, 2 tablets. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The electronic Medication Administration Record (eMAR) did not reflect administration of the Morphine 15 mg on the following dates and time: 1. On [DATE] at 6:54 PM 2. On [DATE] at 8:35 AM 3. On [DATE] at 10:15 AM 4. On [DATE] at 9:49 PM 5. On [DATE] at 9:09 AM On [DATE] at 01:48 PM, the surveyor discussed with the DON the concern regarding the inconsistent accounting, dispensing, and administration of the Morphine 15 mg, five (5) times, in a span of four (4) days without a physician's order; the concern involved eight (8) nursing staff. At that time, the DON acknowledged that a med should not be administered without a physician's order. At that time, the DON stated she was not aware that a facility staff was granted access to the narcotic EBM machine in which a witness was not required. The DON also stated that a nurse should have not had this type of access. At that time, the DON confirmed that she was not aware that the Morphine 15 mg was dispensed and administered without a physician's order. At that time, the DON could not explain how the facility process for accountability and reconciliation missed identification of the removal of the Morphine 15 mg, five (5) times in a span of four (4) days. On [DATE] at 11:22 AM, in the presence of the survey team, the RNVPoCO, the VPoO, the LNHA, and the IP/RN, the DON stated a new process was placed to easily track the on-hand and reconciliation of the narcotics in the EBM. The DON acknowledged that a physician' order was required prior to administration of a med. The DON acknowledged all the concerns and stated education was provided to the nursing staff. 2.) On [DATE] at 01:35 PM, during the observation of the cycle count for the EBM, by the DON and the IP/RN, the surveyor observed the following expired narcotics meds in the EBM: -Oxycontin (narcotic pain med) 10 mg #13 tabs that expired on ,d+[DATE] (at that time, expired for seven months), -Zolpidem (narcotic sleeping pill) 10 mg #2 tabs that expired on [DATE]. -Zolpidem 10 mg #3 tabs that expired on [DATE]. On that same date and time, the DON and the IP/RN confirmed they also observed the expired meds. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At that same time, the DON stated she was unable to remove the expired narcotics from the active inventory stored in the EBM until she received a letter from the CDS (Drug Enforcement Agency, Controlled Dangerous Substance). Furthermore, the DON stated that the nurses would have to look at the expiration date prior to removing a med from the active inventory in the EBM. In addition, the surveyor asked the IP/RN, should an expired narcotic med be intermingled with the active inventory that was stored in the EBM. The IP/RN stated that the correct protocol would be to remove the expired narcotic from the active inventory to avoid med administration error. At that time, the DON acknowledged that the expired narcotic should have been removed from the active inventory. On [DATE] at 11:22 AM, in the presence of the survey team, the RNVPoCO, the VPoO, the LNHA, and the IP/RN, the DON acknowledged the concerns and stated that education was provided to the nursing staff. A review of the provided facility policy; Medication Storage dated/revised [DATE], included the following: Policy: Meds will be stored in a manner that maintains the integrity of the product ensures the safety of the residents and is on accordance with NJ Department of Health guidelines. Procedure F. Expired, discontinues and/or contaminated meds will be removed from the med storage area and disposed of in accordance with facility policy. A review of the undated facility policy; Loss or Theft of Drugs included under Policy; Any theft or loss of drugs must be reported immediately to facility management and appropriate actions taken. A review of the facility policy provided, ADS [Automatic Dispensing System] Station Med Policies and Procedures, effective date of [DATE] included the following: Policy: Nursing and Pharmacy will use the ADS Station as an inventory, charging, and information system for the control and distribution of meds for Emergency, First-Dose use and other situations where meds are not available from the pharmacy. (Not to be used for continuous dosing). NJAC 8:,d+[DATE].2(b), 27.1(1), 29.2(a,d), 29.4 (g), 29.7(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER: Manhattanview Ctr for Rehabilitation and Healthcar		STREET ADDRESS, CITY, STATE, ZIP CODE: 3200 Hudson Avenue Union City, NJ 07087	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 38327 Based on interviews, record review, and a review of pertinent facility documents, it was determined that the facility failed to a.) provide oversight by a licensed Consultant Pharmacist (CP) in March 2024 for four (4) of five (5) residents, (Residents #17, #49, #75, and #80) and the entire month of April 2024, for five (5) of five (5) residents, (Residents #17, #22, #49, #75, and #80), b.) identify the irregularity with regard to physician's order for antipyschotic medication for one (1) of five (5) residents, (Resident #22) reviewed for unnecessary medications in accordance to facility's practice and policy. This deficient practice was evidenced by the following: 1. On 5/07/24 at 11:16 AM, the surveyor observed Resident #22 in the dayroom. The surveyor reviewed Resident #22's hybrid (a combination of paper-based and electronic medical records that primarily involves tracking and storing a patient's health records in several formats and places) medical record (HMR). According to the Admission Record (AR, an admission summary), the resident was admitted to the facility with diagnoses that included but were not limited to major depressive disorder, recurrent, unspecified, essential hypertension (occurs when abnormally high blood pressure that's not the result of a medical condition), unspecified psychosis (a mental disorder characterized by a disconnection from reality) not due to a substance or known physiological condition, anxiety disorder unspecified, and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). A review of the May 2024 Order Summary Report (OSR) included a physician's order (PO) dated 3/26/24 of Seroquel (an antipsychotic medication) oral tablet (tab) 25 mg (milligrams) to give 0.5 mg by mouth at bedtime (HS) for psychosis. The above order for Seroquel was transcribed and signed by nurses as administered from 3/26/24 through 3/31/24, the whole month of April 2024, and from 5/01/24 through 5/08/24. A review of the Progress Notes (PN) created on 3/26/24 at 02:51 PM by the Licensed Practical Nurse (LPN) included that the order for Seroquel 25 mg give 0.5 mg by mouth at HS was outside of the recommended dose or frequency, the daily dose of 0.5 mg was below the usual dose of 12.5 to 1,200 mg. Further review of the PN revealed that there was no Pharmacy Consultant Note (PCN) for March 2024. There was a late entry PCN dated 4/30/24 that included Medications were reviewed. Report provided. A review of the CP monthly Medication Regimen Review (MRR) binder that was provided by the Director of Nursing (DON) showed that there was no report for March, April, and May 2024. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/09/24 at 10:50 AM, the surveyor asked the DON why CP's review for March, April, and May 2024 was not in the blue binders that the DON had provided for the surveyor to review. The DON stated that the facility had not received the CP's review yet. The surveyor then asked the DON for the CP's phone number and she said that she will get back to the surveyor. On 5/09/24 at 11:07 AM, the surveyor interviewed Consultant Pharmacist #1 (CP#1). CP#1 informed the surveyor that she was covering CP. CP#1 stated that the assigned CP, CP#2 was on leave and unable to respond to the surveyor's inquiry which was why CP#1 was the one who called back. On that same date and time, CP#1 informed the surveyor that CP#3, the regular CP of the facility left in early March 2024, and CP#2 was the designated CP then. CP#1 stated that there was a March 2024 MRR review by CP#2 for the 3rd floor but was unable to find or state if the 4th and 5th floor reviews were done. She further stated that there were no MRR reviews for April 2024 for the 3rd, 4th, and 5th floors. CP#1 also stated that she would do the reviews and put it as a late entry after the surveyor's inquiry. She indicated that the May 2024 MRR was still to be done. She acknowledged that MRR for all residents should have been done monthly as required by the facility and regulations. On 5/09/24 at 11:56 AM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Registered Nurse [NAME] President of Clinical Operations (RNVPoCO), VP of Operations (VPoO), and the DON. The surveyor notified the facility management of the above concerns and findings. On 5/09/24 at 01:45 PM, the DON provided a copy of the printed CP's MRR for the date 3/24/24 (printed 5/09/24) for the 3rd floor residents which included Resident #22. The 3/24/24 MRR did not include recommendations or notes that the irregularity for the Seroquel order was identified for Resident #22. There were no March 2024 MRR for the 4th and 5th floors. A review of the facility's Medication Regimen Review Policy with a created date of 11/23 that was provided by the DON included that it is the facility policy to provide an MRR for all residents admitted to the nursing facility. MRR is a thorough evaluation of the medication (med) regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences associated with med. The review includes preventing, identifying, reporting, and resolving medication-related problems, med errors, or other irregularities, and collaborating with other members of the interdisciplinary team. The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. On 5/14/24 at 11:22 AM, the survey team met with the LNHA, DON, Infection Preventionist/Registered Nurse (IP/RN), VPoO, and RNVPoCO. The DON stated and acknowledged that there was no March 2024 MRR for the 4th and 5th floors and for the whole of April 2024 for the 3rd, 4th, and 5th floors according to the facility's practice, policy, and regulations. The DON further stated that the facility was unaware of the reason why there was no MRR done in March and April 2024 not until the surveyor's inquiry. The DON also stated that it was her responsibility to make sure that the MRR was done timely by the CP. At that same time, the DON informed the surveyor that the resident received the right dose of half a tablet (0. 5 tab) of 25 mg Seroquel even though the order was wrong because the pharmacy sent the bingo card (a method of packaging meds in which a blister pack is enclosed in a folded-over card) of half a tab med. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	39885 2. On 5/07/24 at 10:29 AM, the surveyor observed Resident #17 asleep in his/her bed. The surveyor reviewed Resident #17's HMR. The AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), unspecified psychosis and Alzheimer's disease (progressive disease that destroys memory and other important mental functions). Resident #17's PCN revealed that the last MRR was on 02/15/24. Further review of Resident #17's hybrid MR showed that there were no MRRs for March 2024 and April 2024. On 5/14/24 at 12:16 PM, in the presence of the survey team, the surveyor notified the LNHA, DON, IP/RN, VPoO and RNVPoCO the concern that Resident #17 did not have a MRR done after 02/15/24. On 5/15/24 at 12:53 PM, the DON confirmed that Resident #17 did not have a MRR for the two months and that there should have been. The facility did not provide any additional information. 45449 3. On 5/07/24 at 11:02 AM, during the initial tour, the surveyor observed Resident #49 asleep with the head of the bed elevated. The resident was covered with a blanket. The surveyor reviewed the HMR of Resident #49. The AR reflected that that resident was a long-term care (LTC) resident at the facility and had diagnoses which included but were not limited to schizoaffective disorder (is a combination of symptoms of schizophrenia and mood disorder, such as depression or bipolar disorder), adjustment disorder (unhealthy or excessive reaction to a stressful event in a person's life), depression and cognitive communication deficit (difficulty with thinking and how someone uses language). A review of the PCN where the CP documented a brief note that a Report would be provided to the facility. The PN did not reveal an MRR for March 2024. The April 2024 reflected a late entry that was created on 5/09/24 by the CP. A review of the CP Report did not reflect an MRR for March and April 2024. 4. On 5/07/24 at 9:46 AM, the surveyor observed Resident #75 walking up and down the low side of the hallway while using a walker. The resident was pleasant and spoke in [language redacted]. The surveyor reviewed the HMR of Resident #75. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The AR reflected that that resident was a LTC resident at the facility and had diagnoses which included but were not limited to major depressive disorder, unspecified dementia (a group of symptoms affecting memory, thinking and social abilities), unspecified psychosis and adjustment disorder with anxiety. A review of the PCN where the CP documented a brief note that a Report would be provided to the facility. The PN did not reveal an MRR for March 2024 and April 2024. A review of the CP Report did not reflect an MRR for March and April 2024. 4. On 5/07/24 at 11:05 AM, during the initial tour the surveyor observed Resident #80 resting on the bed, in a fetal position with a monitoring device [for residents at risk of wandering] on the left ankle. The resident spoke [language redacted]. The surveyor reviewed the HMR of Resident #80. The AR reflected that that resident was a LTC resident at the facility and had diagnoses which included but were not limited to major depressive disorder, psychotic disorder, anxiety disorder, mild cognitive impairment, and unspecified dementia. A review of the PCN where the CP documented a brief note that a Report would be provided to the facility. The PN did not reveal an MRR for March 2024. The April 2024 reflected a late entry that was created on 5/09/24 by the CP. A review of the CP Report did not reflect an MRR for March and April 2024. NJAC 8:39-29.3 (a)(1)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

45208

REPEAT DEFICIENCY

Based on observation, interview, and review of documentation provided by the facility, it was determined that the facility failed to a) maintain proper kitchen sanitation practices and clean equipment, b) properly store foods in a safe manner to prevent the development of food borne illness, and c) maintain three (3) of three (3) nursing unit pantry used for residents in a sanitary manner.

This deficient practice was evidenced by the following:

On 5/07/24 at 10:16 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD), the FSD Trainer (FSDT) and the Regional FSD (RFSD), and observed the following:

~In the walk-in freezer, several boxes of opened food items that were opened, unlabeled and exposed to freezer with freezer burn and frost on them. Those items were as follows: chicken tenders, salisbury beef steaks, opened loose corn, and pizza. All listed items were opened, unsealed, unlabeled with open date or expiration dates. The FSD manager was unable to say when the packages were opened.

~The food preparation area had a trash can filled with garbage and food debris that was uncovered.

~Two (2) steamer tables with three (3) sections each totaling six (6), was noted to have opaque water with sediment at the bottom which the FSD was able to scoop up and it was determined it was rice and that had not been used this day for a meal. The FSD stated the table water was supposed to be cleaned between meals and daily. The FSD acknowledged that it had not been done per policy.

On 5/07/24 at 10:30 AM, the surveyor interviewed the FSD, who stated that labeling of food was a requirement in his kitchen. The food should be labeled with expiration date and if opened it should be labeled with open date and the package should be resealed to keep the contents fresh. Labeling allows for first in first out concept which saves food integrity, prevents freezer burn, and waste production. She further stated, The cooking equipment is on a cleaning schedule and the findings of the kitchen equipment (steamer table) should have all been cleaned and water changed.

On 5/08/24 at 11:47 AM, the surveyor observed 3 of 3 pantry, one on each nursing unit (3rd, 4th and 5th floor). The purpose of the pantry was for residential use. Each pantry was equipped with a refrigerator, microwave, sink and ice machine.

The surveyor observed in the presence of the Registered Nurse/Unit Manager (RN/UM), the pantry on the 3rd floor nursing unit had build-up of white sediment on the outer lip of the door flap that was wipeable. On the interior back panel where ice dispenses it had a yellowish film that was wipeable by the RN/UM. The 3rd floor pantry had a rectangular plastic bucket that the staff put the ice scoop in. The bottom had a build up of water and orange film in the interior corners that the scoop was sitting in.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/08/24 at 12:10 PM, the RN/UM acknowledged that the ice machine needed to be cleaned and the scoop should not be sitting in stagnant water. She also stated, it should not be like this because the residents use this ice for their drinks, and it can cause an infection or make them sick. On 5/08/24 at 12:28 PM, the surveyor observed in the presence of the Licensed Practical Nurse/Unit Manager (LPN/UM) pantry on the 4th floor nursing unit had build-up of white sediment on the outer lip of the door flap that was wipeable. On the interior back panel where ice dispenses it had a yellowish/ orange film covering the whole panel and on the right side of the interior panel and in the hinge, flap was coated with black sediment. All were wipeable by the LPN/UM. On that same date and time, both the surveyor and the LPN/UM observed the 4th floor pantry had an ice scoop holder mounted to the wall behind the ice machine. The mounted holder was composed of two (2) separate pieces that attached to each other. Neither piece was equipped with drainage holes. The ice scoop was sitting in stagnant water and the bottom of the interior piece was coated with brown and black sediment. When the LPN/UM removed the piece and placed in sink and filled it with water the sediment started to flake off. The scoop tip had cracks in the plastic that were discolored gray. At that same time, the surveyor observed the 4th floor sink, which had black sediment around the sink, caulk, and backsplash areas. On 5/08/24 at 12:55 PM, the Housekeeping Director (HD) came to the 4th floor pantry. The surveyor observed in the presence of the LPN/UM and HD the ice machine, scoop mount, scoop, and the sink, which had black sediment around the sink, caulk, and backsplash areas. On 5/08/24 at 12:58 PM, the surveyor interviewed the HD, he acknowledged that it should be cleaned and further stated, I am shutting the unit down and having it cleaned right now. He further stated, It should be cleaned daily. The surveyor reviewed the black sediment behind, on, and around the sink with the HD and asked to see the Director of Maintenance (DM). The HD stated, I am the HD and the DM in a dual capacity position. The HD acknowledged the sink area and stated, he would have it cleaned and fixed. He further stated, I would need to notify the Licensed Nursing Home administrator (LNHA). On 5/08/24 at 01:03 PM the surveyor, in the presence of the HD toured the 5th floor pantry. The 5th floor pantry had an ice scoop holder mounted to the wall behind the ice machine. The mounted holder was composed of two (2) separate pieces that attached to each other. Neither piece was equipped with drainage holes. The ice scoop was sitting in stagnant water and the bottom of the interior piece was coated with brown and black sediment. On 5/08/24 at 01:06 PM, the HD acknowledged that the holder should have drainage holes to prevent stagnant water buildup which can cause bacteria and mold. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/09/24 at 10:34 AM, the surveyor interviewed the DON, who stated I acknowledge the issues in the 3rd, 4th and 5th floor pantry. I was informed by my UM's and the HD. The DON further stated that the cleaning process was in place to prevent bacteria and possible illnesses that can happen. She also stated that it was everyone's responsibility to keep the units clean. In addition, the DON stated that if a Certified Nursing Assistant (CNA) sees something, they should report to the nurse, the UM, or myself to have it reported to the appropriate department to get fixed or cleaned. The DON further stated that the UM should be doing audits on their floor to make sure items are cleaned and in working order according to policy. On 5/09/24 at 12:42 PM, the surveyor interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated, the reason to have a clean and unsoiled pantry is to prevent pest, rodents, and bacteria. It should be maintained and clean for the residents because this is their home. I will have to do more in-services on the cleaning process. I will set those up with the HD. A review of an updated Dining Services, Food Storage Policy, included: Food items will be stored, thawed, and prepared in accordance with good sanitary practice. Procedures: All products shall be dated upon receipt or when they are prepared. Use date shall be marked on all food containers according to the timetable in dry, refrigerated and freezer storage chart found in this section. Frozen Meat/ Poultry /and Foods: Storage: Foods shall be stored in their original containers if designed for freezing. Foods to be frozen shall be stored in airtight containers or wrapped in heavy duty aluminum foil or special laminated papers. Labels and date all food items. A review of the undated Labeling and Dating System Protocol Policy included: ~follow manufactures expiration date on all un-opened or opened products. If there is no printed date on the product, follow below dating protocol: All frozen foods allowed three days to defrost in cooler. Add those three days to the expiration date on the open/prep and expiration label. All food in freezer storage six months A review of the undated Dining Services, Steam Table Policy which revealed: 1. It is the responsibility of ALL cooks to keep the steam table clean and sanitized every meal. 2. The morning cook will make sure that steam table wells are filled with adequate amount of water (clean) before turning it on. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. The nighttime cook is responsible for always changing the water in each well and to refill each well with adequate amount of water. 4. The steam table must be turned off at night, filled with clean water and each well is covered. A review of the undated Dining Services, Garbage and Trash cans Policy which included: Sanitation of Equipment. All food waste must be placed in covered garbage and trash cans. A review of the Infection Control, Cleaning and Disinfecting Ice Machines and Ice Chest Policy, last revised dated 10/01/23, included: To minimize the potential for infection from proper cleaning and maintenance of ice machines and ice chests. The facility is committed to providing a safe and healthy environment for residents and to minimize or prevent the spread of infections. 2. Ice Scoops: Surfaces of the scoop should be smooth and unbroken. If scoops are cracked or have irregular surfaces, they should be discarded and replaced. Store the scoop in a container with drainage area at the bottom when not in use. Do not rest the scoop in/on any other surface. 3. Ice Machines: Disinfect the drop opening of the ice machine once a month with an appropriate disinfectant. A review of the undated Ice Machine Policy included: Sanitation of equipment: Frequency: Daily Wash exertion of machine. Use sanitizing solution and clean cloth. A review of the Policy: Daily Pantry Room Cleaning, dated 01/2024, included: Steps to be done. 2. Dust all horizontal surfaces with a cloth and disinfectant, wipe all horizontal (flat) surfaces. 4. Spot Clean with a cloth and disinfectant spot clean all vertical surfaces. NJAC 8:39-17.2(g)

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45449 Based on observation, interview, and record review, it was determined that the facility failed to ensure each resident was offered pneumococcal vaccination according to the current Centers for Disease and Control Prevention (CDC) and the Advisory Committee on Immunization Practices (ACIP) recommendations. This deficient practice was identified for two (2) of five (5) residents reviewed for immunization status (Resident #75 and Resident 80). The deficient practice was evidenced by the following: Reference: A review of the CDC guidelines for Pneumococcal vaccination included: For adults [AGE] years and older who only received the Pneumococcal polysaccharide vaccine (Pneumovax/PPSV 23),Give (1) dose of Pneumococcal conjugate vaccine (PCV 15 or PCV20) at least one year after the most recent PPSV23 vaccination. Reference: A review of the ACIP included: On October 21, 2021, the ACIP recommended use of 20-valent pneumococcal conjugate vaccine (PCV20 [Prevnar 20) alone or 15-valent pneumococcal conjugate vaccine (PCV15) in series with 23-valent pneumococcal polysaccharide vaccine (PPSV23) [Pneumovax23) for all adults aged [AGE] years. 1. The surveyor reviewed the hybrid (combination of paper and electronic) medical record (HMR) for Resident #75. According to the Admission Record (AR; an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to chronic obstructive pulmonary disease (COPD; a chronic inflammatory lung disease that causes obstructed airflow from the lungs) and hypertensive heart disease (high blood pressure). Resident #75's most recent quarterly Minimum Data Set (qMDS), an assessment tool used to facilitate the management of care, dated 3/16/24, reflected that the resident was rarely/never understood, and a Brief Interview for Mental Status (BIMS) was not conducted. Further review of the qMDS dated [DATE], under section O0300 A. Was the resident's Pneumococcal vaccine to date? The response was marked 1, which reflected No. Section B. If Pneumococcal vaccine not received, state reason: The response was blank for the following: not eligible, offered and declined and not offered. A review of the electronic Medication Administration Record (eMAR) under Immunization indicated the resident received Pneumovax on 02/05/21. A review of the paper chart did not reflect a record that PCV 15 or PCV20 was offered to the resident. 2. The surveyor reviewed the HMR for Resident 80. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to major depressive disorder and mild cognitive impairment (memory or thinking problems). Resident #80s most recent qMDS dated [DATE], reflected that the resident had a BIMS score of 12 out of 15, which indicated the resident's cognition was moderately impaired. Further review of the qMDS dated [DATE], under section O0300 A. Was the resident's Pneumococcal vaccine to date? The response was marked 1, which reflected No. Section B. If Pneumococcal vaccine not received, state reason: The response was blank for the following: not eligible, offered and declined and not offered. A review of the eMAR under Immunization indicated the resident received Pneumovax on 11/18/23. A review of the paper chart did not reflect a record that PCV 15 or PCV20 was offered to the resident. On 5/13/24 at 11:34 AM, during an interview with the surveyor, the Infection Preventionist/Registered Nurse (IP/RN) stated that the facility and the facility policy followed the CDC guidelines of the Pneumococcal vaccination schedule for adults. The IP/RN stated that the residents who were [AGE] years old and older received PPSV-23 unless contraindicated. The IP/RN informed the surveyor that she was not part of the team that reviewed the facility policy for the Pneumococcal vaccination. On that same date and time, the surveyor notified the IP/RN the concern regarding the Pneumococcal vaccine schedule for Resident # 75 and #80 that were not up to date, and the policy and procedure for pneumonia that did not reflect the current CDC guideline. On 5/13/24 at 12:34 PM, during a follow-up meeting with the surveyor, the IP/RN stated that she had reviewed the current CDC guidelines, Resident #75 and #80's Pneumococcal immunization schedule. The IP/RN further stated that both residents should have received PCV 20 one (1) year after receiving PPSV 23. At that time, IP/RN also stated she should have reviewed the resident's immunization schedule. The IP/RN stated she would call the prescriber to discuss the missing Pneumococcal vaccination, discuss with the resident (when appropriate), discuss with the family, obtain a consent or refusal. She also stated she would conduct an audit of all the immunization. Lastly, the IP/RN stated that she would meet with the Registered Nurse [NAME] President of Clinical Operations (RNVPoCO) to discuss the current CDC guideline for Pneumococcal vaccine. On 5/14/24 at 12:13 PM, during a meeting with the survey team, the RNVPoCO, the [NAME] President of Operations (VPoO), Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the IP/RN, the surveyor discussed the concern regarding the outdated vaccination status for Resident #75, #80 and the outdate policy. On 5/14/27 at 12:37 PM, in the presence of two surveyors, the IP/RN acknowledged that both residents should have received one dose of the PCV 20, one year after receiving PPSV 23 as outlined by the current CDC and ACIP recommendations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315465	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manhattanview Ctr for Rehabilitation and Healthcar	3200 Hudson Avenue Union City, NJ 07087

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility provided policy dated reviewed/revised on 02/2024 reflected under Policy: It is the policy of this facility that all residents will be evaluated at the time of admission for the appropriateness of receiving the Pneumonia Vaccine as per CDC Recommendations. The Procedures included the following: 1. No more vax (vaccine) will be offered to all residents unless it is medically contraindicated, or the resident has already been immunized. There are two types of pneumococcal vaccines available in the country: A. Pneumococcal conjugate vaccine (PCV12 or Prevanar 13) B. Pneumococcal polysaccharide vaccine (PPSV23 Pneumovax 23) N.J.A.C. 8:39-19.4(h), (i), (j)