STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interview, record review, and review of facility documents, it was determined that the facility failed to ensure that a resident who did not have a Pressure Ulcer (PU) upon admission and who was identified at risk of developing a PU, received care and services in accordance with professional standards of practice to prevent PUs. Resident #7 developed a facility acquired unstageable sacral wound identified by the Certified Nursing Aide and deep tissue injuries to bilateral heels identified during wound consultation (both four days after admission). In addition, the facility failed to ensure treatments were ordered at the time of identification. The resident's wounds worsened, developed a wound in another site, and had undergone a surgical debridement (a medical procedure that involves removing dead or infected tissue from a wound). This deficient practice was identified for 1 of 2 residents (Resident #7) reviewed for pressure ulcers.The deficient practice was evidenced by the following: According to the National Pressure Ulcer Advisory Panel (NPUAP), April 13, 2016, the updated staging system includes the following definitions:Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear.Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin.Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD).or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin.Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur.Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur.Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.Deep Tissue Injury (DTI): Persistent non-blanchable deep red, maroon or purple discoloration.or blood filled blister.This injury results from intense and/or prolonged pressure and shear forces at the bone[1]muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4).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 (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 0686 Level of Harm - Actual harm Residents Affected - Few	emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.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 8/14/25 at 10:03 AM, Surveyor #1 (S#1) met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) during entrance conference and asked for the facility's list of residents with facility acquired wounds.On 8/14/25 at 10:25 AM, S#1 observed an enhanced barrier precautions (EBP) signage outside Resident #7's room. Resident #7 was awake, lying on an air mattress, with a urinary bag hung on the side of the bed contained within a privacy bag.At that same time, Resident #7 informed S#1 that they had cancer in their spine and had been at the facility for three months. The resident stated that they had wounds on their back and feet. The resident further stated that the Wound Doctor (WD) came that morning and debrided the wound on their back. On 8/14/25 at 11:08 AM, the Infection Preventionist/Licensed Practical Nurse (IP/LPN) informed S#1 that Resident #7's wounds were hospital acquired.S#1 reviewed the medical records of Resident #7, which revealed the following:According to the admission Record or face sheet (an admission summary) Resident #7 was admitted to the facility with diagnoses which included but not limited to; other low back pain, neoplasm related pain (acute) (chronic), spinal stenosis cervical region, pressure ulcer of sacral region unstageable (a type of wound that occurs when pressure on the skin causes tissue damage that cannot be accurately assessed or staged due to the presence of necrotic tissue (slough or eschar), malignant neoplasm (cancer) of vertebral column, malignant neoplasm of left kidney except renal pelvis, and muscle wasting and atrophy not elsewhere classified multiple sites.A review of the hospital records, with an attestation by a physician dated 5/18/25 at 9:02 AM, revealed that the resident was seen and evaluated at the bedside and the resident's skin had no impairment. The hospital notes did not include any information that the resident was on skin and/or pressure ulcer treatment upon discharge (d/c) from the hospital.A review of the admission Summary completed by Licensed Practical Nurse #1 (LPN #1) in the electronic health system (EHR) dated 5/18/25 at 6:57 PM, revealed, Resident arrived via stretcher from [hospital name]. No wounds noted on body.A review of the admission Assessment, revealed that the resident was admitted to the facility with incontinence, was chair-fast, had no pressure ulcer, no foot problems, and the preventative approaches/equipment included a turning and positioning (T & P) program. The Braden Scale for Predicting Pressure Sore Risk score upon admission was 17 (at risk).A review of Resident #7's Progress Notes (PN) revealed:A Physician History & Physical Exam, with an effective date of 5/20/25, that was electronically signed by the Medical Doctor (MD), reflected that resident's skin was normal.A Late Entry: Health Status Note (HSN) with an effective date of 5/21/25, created on 5/25/25, that was electronically signed by previous DON (pDON), reflected that the CNA reported the resident having an opening to the sacrum. The nurse assessed, no c/o (complaint of) pain. Cleansed with normal saline (NS), applied medihoney (with 100% Leptospermum honey, offers powerful antibacterial properties, making it highly effective against a broad spectrum of bacteria, including those that are typically resistant to other treatments, ensuring consistent effectiveness in wound management.) and border gauze. Notified the MD and ordered a wound consult.A skin/Wound Note with effective date of 5/23/25, that was electronically signed by the pDON, reflected an unstageable DTI of the right heel, measuring 1.5 cm (centimeter) x 1.5 cm, and with new order for skin prep.A Health Status Note (HSN) with effective date of 5/25/25, that was electronically signed by Licensed Practical Nurse #2 (LPN#2), reflected that resident's air mattress was found with low pressure, another mattress was brought down to the 1st floor but was not working, a second air mattress was (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	tried and was not working, and the two non-working mattress were left on the 8th floor inflating.Further review of the PN revealed that there was no other documentation that a functional air mattress was provided to the resident. A review of the Wound Consult Notes for Resident #7 revealed:Date of service (DOS): 5/23/25, the resident presented with:Unstageable DTI to the sacrum with undetermined thickness, measuring 6 cm x 10 cm x 0.4 cm, open ulceration, erythema periwound, and tx (treatment) plan: leptospermum honey (also known as medihoney) apply once daily (OD) and PRN (as needed) ; Unstageable DTI of the right heel undetermined thickness, measuring 1.5 cm x 1.5 cm and left heel 1 cm x 1 cm, both intact with purple/maroon discoloration, and tx plan: skin prep apply OD and PRN. General recommendations: float heels in bed, limit sitting to 60 minutes, off load wound(s), reposition, turn side-to-side in bed, cleanse wounds with saline daily with dressing changes.DOS: 5/30/25, the resident presented with:Unstageable (due to necrosis) to sacrum full thickness, measuring 7 cm x 12 cm and tx plan: Santyl OD and PRN. Surgical excisional debridement procedure and removed necrotic tissue; Stage 2 pressure of the right heel (5 cm x 8 cm, open ulceration) and left heel (3.2 cm x 5.6 cm, open areas with exposed dermis), both partial thickness, with blood filled blister, and tx plan: skin prep apply OD and PRN; Unstageable DTI of the left, lateral ankle undetermined thickness, measuring 1 cm x 0.8 cm, intact with purple/maroon discoloration, and tx plan: skin prep apply OD and PRN.DOS: 6/6/25, the resident presented with:Stage 4 pressure wound sacrum full thickness, measuring 8 cm x 15 cm and tx plan: Santyl apply OD and PRN. To residual necrotic tissue along wound edge, leptospermum honey apply OD and PRN. Post debridement assessment of this previously unstageable necrotic wound had revealed the underlying deep tissue at the muscle/fascia level, which had been obscured by necrosis prior to this point; Stage 2 pressure of the right heel (5 cm x 10 cm, open ulceration) and left heel (3.1 cm x 4 cm, open areas with exposed dermis), both partial thickness, with blood filled blister, and tx plan: skin prep apply OD and PRN; Unstageable DTI of the left, lateral ankle undetermined thickness, measuring 0.6 cm x 0.5 cm, intact with purple/maroon discoloration, and tx plan: skin prep apply OD and PRN. DOS: 6/13/25, the resident presented with:Stage 4 pressure wound sacrum full thickness, measuring 9 cm x 17 cm x 0.3 cm, and tx plan: Santyl apply OD and PRN. To residual necrotic tissue along wound edge, leptospermum honey apply OD and PRN; Stage 2 pressure of the right heel and left heel both partial thickness, with blood filled blister, and tx plan: skin prep apply OD and PRN; Unstageable DTI of the left, lateral ankle undetermined thickness, measuring 0.5 cm x 0.5 cm, intact with purple/maroon discoloration, and tx plan: skin prep apply OD and PRN. DOS: 7/3/25 (new wound company), the resident presented with:Stage 4 pressure wound sacrum, measuring 14.5 cm x 13 cm x 4 cm, moderate serosanguineous (drainage), and tx plan: cleanse wound with Vashe, apply santyl, pack wound with calcium alginate, cover with border foam, change twice a day (BID) and PRN. Low air loss mattress. Surgical debridement procedure done; Unstageable pressure injury obscured full thickness skin and tissue loss of the left heel (3 cm x 4.8 cm) and right heel (4.5 cm x 9.5 cm), scant serosanguineous (drainage), and tx plan: cleanse wound with normal saline (NS), apply skin prep, cover with bordered gauze, change daily and PRN. Foam boots and heels off bed. Surgical debridement procedure done; Left, lateral lower leg resolved.The recommendations for wound care continued 7/10 and 7/17/25, for the following:Stage 4 pressure wound sacrum tx plan: cleanse wound with Dakin's solution, apply collagen powder to wound base, pack wound with calcium alginate, cover with border foam, change daily and PRN. Low air loss mattress. Surgical debridement procedure done; Unstageable pressure injury obscured full thickness skin and tissue loss of the left heel tx plan: cleanse wound with NS, apply hydrogel, cover with border gauze, change daily and PRN. Foam boots and heels off bed; Unstageable pressure injury obscured full thickness skin and tissue loss of the right heel tx plan: cleanse wound with NS, apply medihoney, cover with border gauze, change daily and PRN. Foam boots and heels off bed; Left lateral lower leg, Stage 1 pressure injury tx plan: cleanse wound with NS, apply skin prep, cover with border gauze, change daily and PRN. Frequent repositioning and foam boots.DOS: 7/24/25, the resident presented with:Stage 4 pressure wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	sacral, thigh, and bilateral heels wounds, and they were not facility acquired. LPN#3 was unable to provide documentation that Resident #7's wounds were not facility acquired wounds.On 8/20/25 at 10:12 AM, the MDS Coordinator (MDSC) informed S#1 that the initial comprehensive MDS was modified on 5/25/25, to reflect that the resident had three DTIs that were facility acquire wounds according to the WD consult notes that were uploaded late (wound notes 5/23/25 was uploaded 6/3/25).On 8/20/25 at 11:28 AM, S#1 interviewed LPN #2 regarding the process for admission. LPN#2 informed S#1 that as facility practice, when a resident was admitted , an assessment would be done that included a skin assessment. He stated that the skin assessment would include the Braden scale, whether the skin was intact or not, and then a preventative order would be put in place. He further stated that it would be the Assistant DON (ADON) or the DON who would initiate the CP, and a nurse would verify with the doctor on what tx to order. He also added that there was a contractor who comes to the facility every Thursday to do wound rounds, and every week, we re-evaluate the wound on shower days, and I look at it every day.On that same date and time, LPN #2 informed S #1 that Resident #7 came in with a sacral wound and was unsure about the bilateral heels. S #1 asked if he recalled on admission resident's skin and if any tx was ordered and he responded, I'm not sure.On 8/20/25 at 11:44 AM, the DON in presence the of the survey team confirmed that there was no documented evidence in the resident's medical records that the resident was admitted with unstageable wounds. She further stated that the nurse failed to capture the sacral and bilateral heels unstageable wounds upon admission. The DON informed the survey team that there was an investigation that was initiated in May when the unstageable wound opened.On 8/20/25 at 12:00 PM, S#2 asked the DON for the 5/21/25 wound investigation.A review of the provided New Skin Issue investigation that was provided by the DON revealed that on 5/21/25, the CNA reported to the nurse that the resident had an opening to the sacrum, assessment was done, the MD was notified and ordered medihoney and a wound consult.On 8/20/25 at 12:01 PM, S#1 interviewed the IP/LPN regarding resident's wounds, and she stated the resident had a DTI to the sacrum, boggy with redness and red heels when I saw that Thursday during wound rounds, it was unstageable. The IP/LPN further stated that she did not see the resident's skin on admission.At that same time, the IP/LPN stated that if there was any tx from the hospital, it would be carried over to the facility, and if there was none, it meant the resident's skin was intact. On 8/20/25 at 1:24 PM, the survey team met with the LNHA and DON, and S#1 notified them of the above findings and concerns. On 8/21/25 at 9:09 AM, S#1 interviewed the pDON regarding Resident #7's wounds. The pDON stated the resident came from the hospital with a DTI and the nurse obtained an order from the MD for medihoney. The pDON further stated that subsequent visit of the WD, the order was changed to Santyl which debrided the wound. S#1 asked the pDON if the resident had any tx or interventions upon admission, and he replied that the hospital did not have any tx orders for the resident. S#1 asked if the nurse obtained a medihoney tx order would it be expected to be in the eTAR, and he replied yes. S#1 asked if any other interventions or preventative measures for skin impairment were implemented upon admission for the resident. The pDON stated that an air mattress was ordered and had issues with the mattress deflating, which he reported to the LNHA, and a new mattress was ordered which the resident now had. He also stated that the documentation for an air mattress should be seen in the resident's CP and physician orders.At that same time, S#1 asked about the wound consult and how soon would wound recommendations be followed up after the consultant's visit. He stated that the same day wound rounds were done, the recommendations would be reviewed and carried out. S#1 asked about recommendations from May for skin prep to bilateral heels and why it was not carried out onto the eTAR, (not until 7/3/25) and he responded that he did not know what happened and could speak about it. On 8/21/25 at 9:18 AM, the pDON stated that resident came in with a DTI and had heel boots, but it was not documented by the nurses. He also stated that the ADON and DON were responsible for putting in orders and completing wound rounds.On 8/21/25 at 11:00 AM, S#3 discussed with the DON the interview with the pDON with regard to the broken air mattress upon admission. The DON stated (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and review of facility provided documentation, it was determined that the facility failed to ensure that the Certified Nursing Aides (CNAs) received a performance review for 5 of 5 CNA files reviewed. This deficient practice was evidenced by the following:On 8/18/25 at 11:53 AM, the surveyor requested from the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the annual education, competencies and performance reviews for five randomly selected CNAs.The facility provided a copy for each of the five CNAs which contained Nursing Assistant Clinical Skills Checklist and Competency forms and in-service education sign in sheets for education topics. The facility did not provide performance reviews for the five CNAs. On 8/19/25 at 1:59 PM, the surveyor asked the DON if the CNA performance evaluations were available. The DON stated that she could not locate them and if they were not with the Human Resources Department, they may not be in the building.On 8/19/25 2:15 PM, the survey team met with the DON and LNHA for concerns. The surveyor notified the DON and LNHA of the concern with the 5 out of 5 requested performance reviews for CNAs that were not available. The DON stated they did not have them. The surveyor requested any policies related to employee performance reviews.On 8/21/25 at11:56 AM, the survey team met with the LNHA, DON and Regional Director of Nursing for responses to concerns. The DON stated that moving forward, performance reviews were to be included in the employee files and kept on site in the DON's office.The facility did not provide any further pertinent information.N.J.A.C. 8:39-43.17 (b)

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	315525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, it was determined that the facility failed to assure that the required staff attended the quarterly Quality Assurance (QA) meetings for 4 of 6 (Medical Director) and 2 of 6 (Infection Preventionist) quarterly QA meetings according to the regulation and facility's practice. This deficient practice was evidenced by the following:On 8/18/25 at 1:56 PM, Surveyor #1 (S#1) reviewed the provided Quality Assurance Performance Improvement (QAPI) binder and revealed: On 3/28/24 QAPI meeting, the facility management signed the attendance sheet that included the Medical Director (MD), Licensed Nursing Home Administrator #1 (LNHA#1), Director of Nursing #1 (DON#1), and Infection Preventionist #1 (IP#1). On 6/24/24 QAPI meeting, the MD, LNHA#1 and IP#2 signed the attendance sheet. The DON did not sign and there was no report from the DON.For June-August 2024 QAPI meeting, dated 8/29/24, LNHA#1, DON#1, and IP#2 signed the attendance sheet. The MD did not sign.For December 2024 (September-November) QAPI meeting, dated 12/18/24 LNHA#1, DON#1, and IP#2 signed the attendance sheet. The MD did not sign. For February 2025 QAPI meeting, dated 3/27/25, LNHA#1 and DON#2 (also known as IP#2 who had a personnel action form changed position to DON) signed the attendance sheet. The IP and the MD did not sign and there was no report from the IP. For Quarterly QAPI 2025 (March-May) meeting, dated 6/26/25, LNHA#1 and DON#2 signed the attendance sheet. The MD and IP did not sign and there was no report from the IP.On 8/19/25 at 9:00 AM, IP#3 confirmed that she attended the QAPI meeting on 5/29/25, and reported for QAPI. She also stated that she did not attend the 6/26/25 QAPI.On 8/19/25 at 2:15 PM, the survey team met with LNHA#2 and DON#1, and S#1 notified them of the above concerns that the MD and IP did not attend the quarterly meeting routinely. S#1 notified LNHA#2 and DON#1 that the MD was called and did not return the call for an interview. At that same time, both LNHA#2 and DON#1 stated that the QAPI meeting schedule was announced in morning meeting. S#1 asked if the MD attends the morning meeting and the DON stated no, it was being relayed verbally when the MD was in the facility. On 8/20/25 at 8:25 AM, DON#1 provided an employee timeline from March 2024 to present for the following positions:DON: DON#1 was the DON from March 2024 to 3/8/25 DON#2 was the DON from 3/8/25 to 7/6/25 DON#1 was the DON from 7/7/25 to presentIP: IP#1 was the IP from March 2024 to 6/2/24 IP#2 was the IP from 6/2/24 to 3/7/25 IP#1 was the interim IP from 3/7/25 to 5/7/25 IP#3 was the IP from 5/7/25 to presentOn 8/20/25 at 1:06 PM, the survey team met with LNHA#2 and DON#1. S#1 asked LNHA#2 and DON#1 if there was a response with regard to surveyor's concern with QAPI attendance of the MD and IP, and the DON stated no response. On 8/21/25 11:55 AM, the survey team met with the Regional DON (RDON), LNHA#2, and DON#1. S#2 asked if any additional responses and if the survey team could proceed with decision making. DON#1, LNHA#2, and RDON confirmed they had no additional responses, and the team could proceed with decision making.A review of the facility's Quality Assurance Performance Improvement Plan that was provided by the Regional LNHA (previously LNHA#1), dated 6/2024, revealed that the facility's purpose is to provide excellent quality resident care and services.The QAPI Committee will consist of the following representatives: Administrator, DON, Assistant DON, Social Service Director, Director of Rehab Services, Director of Food Service, Activities Director, Medical Director, Human Resources Director, Director of Support Services, Director of Maintenance and at least two non-licensed staff people on a rotating basis/Community Representative.On 8/21/25 at 12:39 PM, DON#1 stated that the facility did not have MD job description. S#2 asked if there was an agreement the MD signed regarding their job description. DON#1 stated that she would check and ask other management.N.J.A.C. 8:39-33.1(a)(b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview, review of medical records, and other pertinent facility documentation, it was determined that the facility failed to follow appropriate COVID testing according to standards of clinical practice, facility's policy and procedure, and Centers for Disease Control and Prevention (CDC) guidelines. This deficient practice was identified for 10 of 16 facility staff (6 Certified Nursing Aides, 1 Registered Nurse, and 3 Licensed Practical Nurse) reviewed for COVID-19 testing. This deficient practice was evidenced by the following:According to the CDC guidelines, Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2, March 18, 2024,.For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period.For this guidance it is defined as: a) being within 6 feet of a person with confirmed SARS-CoV-2 infection or b) having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.Determining the time period when the patient, visitor, or HCP (Health Care Personnel) with confirmed SARS-CoV-2 infection could have been infectious:For individuals with confirmed COVID-19 who developed symptoms, consider the exposure window to be 2 days before symptom onset through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions.For individuals with confirmed SARS-CoV-2 infection who never developed symptoms, determining the infectious period can be challenging. In these situations, collecting information about when the asymptomatic individual with SARS-CoV-2 infection may have been exposed could help inform the period when they were infectious.If the date of exposure cannot be determined, although the infectious period could be longer, it is reasonable to use a starting point of 2 days prior to the positive test through the time period when the individual meets criteria for discontinuation of Transmission-Based Precautions for contact tracing. On 8/14/25 at 8:50 AM, the Director of Nursing (DON) informed the survey team that the facility was in an outbreak for COVID-19 and there were two residents who tested positive for COVID-19 who were in [NAME] unit of the facility. On 8/14/25 at 10:03 AM, Surveyor #1 (S#1) met with the Licensed Nursing Home Administrator (LNHA) and DON during entrance conference, and S#1 asked them for the facility's COVID-19 testing and line listing. On 8/18/25 at 12:50 PM, S#1 reviewed the line listing that was provided by the Regional LNHA (RLNHA), revealed:-Resident #39=tested positive for COVID-19 on 8/4/25-Resident #31=tested positive for COVID-19 on 8/7/25 On 8/19/25 at 9:00 AM, the Infection Preventionist/Licensed Practical Nurse (IP/LPN) provided a copy of the facility's contact tracing that included list of staff who were tested for COVID-19, and revealed:-On 8/4/25 COVID-19 case, there were two Certified Nursing Aides (CNAs) and two nurse that were tested for COVID-19. The results were negative for days 1, 3, and 5.-On 8/7/25 COVID-19 case, there were one CNA and one nurse that were tested for COVID-19. The results were negative for days 1, 3, and 5.-there were two residents and four therapists who were tested for both dates of COVID-19 cases and results were negative. On that same date and time, S#1 asked the IP/LPN as to why there were only three CNAs and nurses that were tested for COVID-19 for days 1, 3, and 5. S#1 also asked what the facility's practice and policy with regard to COVID-19 was testing, and the IP/LPN had no response. On 8/19/25 at 9:59 AM, S#1 interviewed the DON in the presence of the LNHA. The DON informed the survey team that as facility's practice, the COVID positive resident and roommate should be tested for COVID-19 on days 1, 3, and 5. She further stated that all staff who had contacted with the resident should be tested for COVID-19 on days 1, 3, and 5, and usually those staff who worked within 24 hours or three shifts. S#1 notified the LNHA and DON of the above findings and concerns that there were two CNAs and one nurse each identified COVID positive dates that were tested for COVID-19. On 8/20/25 at 11:43 AM, the DON provided a copy of the CNA Assignment for [NAME] side (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and revealed the following:-8/3/25 7:00 AM to 3:00 PM (7-3 shift): Assignment 2 CNA#1 and Registered Nurse #1 (RN#1)-8/3/25 3:00 PM to 11:00 PM (3-11 shift): Assignment 3 CNA#2 and LPN#1-8/3/25 11:00 PM to 7:00 AM (11-7 shift): Assignment 2 CNA#3, LPN#1, and LPN#2-8/4/25 7-3 shift: Assignment 2 CNA#4 and LPN#3-8/4/24 3-11 shift: Assignment 2 CNA#5 and LPN#3-8/4/25 11-7 shift: Assignment 2 CNA#6, RN#1, and LPN#4-8/6/25 7-3 shift: Assignment 3 CNA#7 and LPN#5-8/6/25 3-11 shift: Assignment 3 CNA#6 and LPN#5-8/6/25 11-7 shift: Assignment 2 CNA#6 and RN#2-8/7/25 7-3 shift: Assignment 2 CNA#8 and LPN#5-8/7/25 3-11 shift: Assignment 3 CNA#5 and LPN#5-8/7/25 11-7 shift: Assignment 2 CNA#3 and RN#2 Further review of the above CNA assignments (that included nurses) and COVID testing revealed that RN#1, LPN#3, LPN#5, CNA#2, CNA#6, and CNA#9 (who was not in Residents #31 and #39's CNA assignment) were the facility staff that were tested for COVID-19 on days 1, 3, and 5. On 8/20/25 at 1:06 PM, the survey team met with the LNHA and DON. S#1 asked the LNHA and the DON if they had response for the above concerns about staff COVID-19 testing, the LNHA and DON had no response. A review of the facility's COVID-19 Testing Policy that was provided by the IP/LPN, revealed that the facility will implement testing of facility residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19. Definitions: close contact refers to someone who has been within 6 feet of a COVID-19 positive person for a cumulative total of 15 minutes or more over a 24 hour period.Facility Staff includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. On 8/21/25 at 1:18 PM, the survey team met with the LNHA, DON, Regional DON, and Regional of Operations. S#2 asked if there were any additional information and the LNHA did not provided additional information. NJAC 8:39-11.2(b), 19.4(a)(2),e

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, it was determined that the facility failed to offer and administer resident a pneumococcal vaccine. This deficient practice was identified for 4 of 5 residents (Residents #5, #7, #52, and #62) reviewed for immunizations. This deficient practice was evidenced by the following: 1.On 8/19/2025 at 12:00 PM, Surveyor #1 (S#1) reviewed Resident #5's hybrid medical record. A review of Resident #5's admission Record or face sheet (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; Schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), heart failure (a condition where the heart cannot pump enough blood to meet the body's needs), and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body). A review of Resident #5's comprehensive Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 7/7/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that Resident #5's cognition was severely impaired. Further review indicated that the pneumonia vaccine was offered and declined. A review of the Immunization section in the electronic medical record (EMR) revealed that the pneumococcal vaccine was offered, POA (power of attorney) refused, risks explained, refusal form obtained as verbal from POA, dated 9/28/22. There was no documented evidence in the hybrid medical record that the pneumococcal vaccine was offered for the Resident's current admission to the facility in July 2025. On 8/19/25 at 11:50 AM, S#1 interviewed the Infection Preventionist/Licensed Practical Nurse (IP/LPN) regarding process for offering the pneumonia vaccine. The IP/LPN stated that she would look up the resident's vaccine record and that it would be offered if eligible and would be documented in the immunization section of the EMR. The IP/LPN stated that she was currently going through all the resident's and getting consents for the influenza and pneumonia vaccines. She further stated that she started last week and that for residents that had refused in the past she would ask again. S#1 asked when the pneumonia vaccine should be offered and she stated that it should be offered upon admission. S#1 asked the IP/LPN the status of Resident #5, and she stated that she called resident's representative #1 (RR#1) and waiting for them. She added that RR#1 did not answer and that she did not document the attempted phone call in the medical record. S#1 then asked the IP/LPN about the MDS that had offered and declined and the refusal was dated 9/2022. The IP/LPN stated that she did not know why the MDS Coordinator (MDSC) had put offered and declined. On 8/20/25 at 12:01 PM, S#1 interviewed the MDSC regarding Resident #5's MDS and pneumonia vaccine. The MDSC stated that she had looked in the immunization section and saw the refused and coded as such. S#1 asked if she checked the date for the entry in the immunization section to see if it was up to date. The MDSC stated that she would have to check and get back to S#1. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/25 at 1:23 PM, S#1 notified the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) the concern that Resident #5 did not have the pneumonia vaccination offered upon admission. On 8/21/25 at 12:01 PM, in the presence of the LNHA, the DON stated that Resident #5 had refused the vaccine in Assisted Living but that was September 2022. The DON stated that she in-serviced staff and will start a Quality Assurance Performance Improvement (QAPI). 2.A review of the AR of Resident #7 revealed that the resident was admitted to the facility with diagnoses which included but not limited to; other low back pain; neoplasm related pain (acute) (chronic), spinal stenosis cervical region, pressure ulcer of sacral region unstageable, malignant neoplasm of vertebral column, malignant neoplasm of left kidney except renal pelvis, muscle wasting and atrophy not elsewhere classified multiple sites, anxiety disorder unspecified, and depression unspecified. A review of the cMDS with an ARD of 5/25/25, reflected a BIMS score of 14 out of 15, indicating intact cognition. The MDS also reflected the pneumonia vaccine as offered and declined. A review of the immunization record revealed that the pneumococcal vaccine status was pending immunization, consent confirmed by the IP/LPN on 8/5/25. On 8/18/25 at 11:54 AM, Surveyor #2 (S#2) interviewed the IP/LPN, who informed S#2 that the facility's process with regard to immunization was to obtain the immunization records of the resident via a we based vaccine registry, ask the resident, and verify with resident's physician the history of the resident's immunization. She also stated that she also try to get the records from the hospital but the hospital did not call her back. The IP/LPN added that she did not document about that she contacted the hospital inquiring about resident's immunization records. At that same time, the IP/LPN informed S#2 that she provided a consent form but did not use a declination form, and stated, I usually enter the information in the EMR that it was refused and education was given. She confirmed that she obtained a consent for pneumonia vaccine on 8/5/25, and would administer it next month, and that she would place an order to the pharmacy. On 8/19/25 at 2:32 PM, S#2 notified the LNHA and the DON of the above concern. On 8/20/25 at 10:12 AM, the MDSC stated that she reviewed the immunization detail in the EMR and that was how she coded the resident's MDS. She also stated that she did not write notes regarding the resident's vaccination. On 8/20/25 at 12:01 PM, the MDSC informed S#2 that she reviewed the EMR and that the resident's immunization record showed that the pneumococcal vaccine was pending, and that no other option in the MDS to code it that was why she coded the MDS offered and declined. On 8/20/25 at 1:07 PM, the survey team met with LNHA and DON, and the DON stated, If there was no information, it should be offered. 3.On 8/18/25 12:03 PM, Surveyor #3 (S#3) reviewed the EMR of Resident #52 for immunizations. A review of the AR reflected that the resident was admitted to the facility and had diagnoses that (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included but were not limited to; Parkinson's disease (a nervous system disorder exhibited by tremors), hypertension (high blood pressure), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). A review of the quarterly MDS (qMDS), with an ARD of 6/11/25, reflected a BIMS score of 14 out of 15, which indicated the resident had no cognitive impairment. The qMDS reflected that the resident's pneumococcal vaccine was not up to date and was not offered. A review of the immunizations listed in the EMR revealed there was no documentation regarding the resident's pneumococcal vaccination status. A review of the resident's personalized Care Plan (CP), reflected a refusal of COVID-19, and Influenza vaccines dated 2/28/25. The CP did not reflect any information for pneumococcal vaccination status. A review of the Order Summary Report, did not reflect any orders for administration of a pneumococcal vaccine. On 8/18/25, S#3 reviewed the hard copy chart of Resident #52, which revealed there was no documentation of administration or declination for the pneumococcal vaccine. On 8/20/25 at 12:55 PM, S#3 interviewed the IP/LPN regarding Resident #52's pneumococcal vaccination status and how it was documented. The IP/LPN stated that the immunization record of the resident should be documented in the EMR. She further stated that moving forward there would be a note added in the resident's progress notes (PN). On 8/20/25 at 1:06 PM, the survey team met with the DON and LNHA, and S#3 notified them of the above concerns. On 8/21/25 at 11:56 AM, the survey team met with the LNHA, DON and Regional DON (RDON), and the DON stated that they would conduct staff in-service education and QAPI interventions moving forward for the offering and education of residents for the pneumococcal vaccine. 4.On 8/18/25 at 11:20 AM, Surveyor #4 (S#4) reviewed the EMR of Resident #62 for immunizations. A review of the AR reflected that Resident #62 had diagnoses that included but were not limited to; type 2 diabetes mellitus, hypertension (high blood pressure), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). A review of the cMDS assessment, with an ARD of 7/30/25, reflected a BIMS score of 3 out of 15, which indicated the resident had severe cognitive impairment. Section O of the MDS indicated the resident's pneumococcal vaccine was not up to date and was not offered. Under immunizations listed in the EMR revealed there was no documentation regarding the resident's pneumococcal vaccination status. A review of the PN revealed there was no documentation regarding the resident's pneumococcal vaccination status. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/18/25 at 11:56 AM, S#4 reviewed the hard copy chart of Resident #62, which revealed there was no documentation of administration or declination for the pneumococcal vaccine. On 8/18/25 at 11:59 AM, S#4 interviewed the Licensed Practical Nurse (LPN) regarding immunizations. The LPN stated the IP/LPN was responsible for assessing and following up on resident's immunizations. On 8/19/25 at 10:51 AM, S#4 interviewed the IP/LPN, who stated she was responsible for assessing and reviewing the residents' immunizations. The IP/LPN explained she would review the state online database for resident's vaccination records and asked residents and/or Resident's Representative #2 (RR#2) about vaccination status upon admission. She further stated that vaccines would be offered to residents if they wished to receive them. The IP/LPN also stated that immunizations would be documented under the immunizations section of the EMR. At that same time, S#4 asked the IP/LPN about Resident #62's pneumococcal vaccination documentation and history. The IP/LPN stated Resident #62 was newly admitted to the facility in July 2025, and that she had to speak with RR#2 to ask about the pneumococcal vaccine. The IP/LPN stated that she did not discuss with the resident and/or RR#2 yet to offer the pneumococcal vaccine. S#4 asked the IP/LPN if there was a reason why she had not followed up with RR#2, and she replied that she was following up on obtaining other residents' consents for vaccination and she did not get to Resident #62's yet. On 8/19/25 at 2:15 PM, S#4 notified the LNHA and the DON about the concern that the resident was not assessed or offered a pneumococcal vaccine. On 8/20/25 at 1:06 PM, the LNHA and the DON met with the survey team. The DON stated that there was no additional information regarding Resident #62's pneumococcal vaccine. A review of the undated facility's Pneumococcal Vaccine Policy, revealed, all residents will be offered the Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections. Under Policy Interpretation and Implementation revealed:. 1. Prior to or upon admission, residents will be assessed for eligibility to receive the Pneumovax, and when indicated, will be offered the vaccination within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated . 2. Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. N.J.A.C. 8:39-19.4 (i)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and review of facility documentation, it was determined that the facility failed to ensure that Certified Nurse Aides (CNA) received at least twelve hours of mandatory in-service training for 5 of 5 CNAs education reviewed.This deficient practice was evidenced by the following: On 8/18/25 at 11:53 AM, the surveyor requested, from the Director of Nursing (DON), employee files consisting of but not limited to staffing, competencies, and educational in-services for five randomly selected CNAs. The DON stated that the Infection Preventionist/Licensed Practical Nurse (IP/LPN) was responsible for all the staff education.On 8/19/25, the surveyor reviewed the facility provided in-service education for five randomly selected CNAs, which revealed the following:Five of five Nursing Assistant Clinical Skills Checklist and Competency evaluations had no hours listed as education and did not include topics such as Abuse Prevention. Eight in-service education attendance sheets with dates including 1/28/25, 2/5/25, 3/3/25, 4/8/25, 5/13/25, 6/3/25, 8/1/25, and 8/4/25. Each sheet reflected a time of sixty minutes duration, but did not reflect any topic related to Abuse or Abuse Prevention, or Quality Improvement Performance Improvement (QAPI). The eight sheets provided reflected a total of eight hours education.On 8/19/25 at 1:38 PM, the surveyor interviewed the IP/LPN about staff education. The IP/LPN stated that staff education was on paper. The IP/LPN further stated that they go to each shift and education was provided to the staff who were on the schedule, and she come in on the weekend to find other staff. The IP/LPN added that they just use a general staff list and did not have a tracker or log.At that same time, The IP/LPN stated that they believed it was annual by calendar and was not aware it was by hire date on how to monitor the CNAs mandatory in service. The surveyor asked for a policy for mandatory staff in-services.On 8/20/25 at1:06 PM, the survey team met with DON and Licensed Nursing Home Administrator (LNHA), and the surveyor notified them of the above concern with the employee education files not having the required 12 hours and not having mandatory topic such as Abuse, Abuse Prevention, Facility Assessment, and QAPI (Quality Assurance Performance Improvement). The DON stated that they would provide further evidence for educational in-services with such topics as abuse with electronic recordsOn 8/20/25 at 2:02 PM, the DON informed the surveyor there was no electronic education records for 2024, and stated that it was for 2023 only.On 8/21/20 at 11:56 AM, the survey team met with the DON, LNHA and Regional DON (RDON), and the DON stated that the staff in charge of education would be in-serviced, there would be a QAPI started to ensure the education was kept up to date, and the documents would be kept on site in the DONs office. The DON also stated that there were previous employees that were responsible for keeping the documents current.A review of the facility's Prohibition of Resident Abuse and Neglect Policy, dated 7/18/22, reflected, under Training: 1. Employees will receive abuse prevention training at orientation and annually.The facility did not provide any further pertinent information. N.J.A.C. 8:39-43.17(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of other facility documentation, the facility failed to ensure the facility was maintained in a safe, clean, and homelike environment. This deficient practice was identified for 3 of 4 Resident Rooms (Rooms 7,11, and 29) and 1 of 2 shower rooms. This deficient practice was evidenced by the following: 1.On 8/18/25 at 10:38 AM, Surveyor #1 (S#1) with the Housekeeping Director (HD) toured the [NAME] unit and did random tour of the unit rooms. Both S#1 and the HD went inside Resident room [ROOM NUMBER] (RR#11). Upon entry, on the right side the closet was unable to fully closed, and the HD moved the clothes inside the closet and stated that there were too much residents' clothes inside the closet that was why it was not closing well. Both S#1 and the HD observed the toilet room with no paper towel. The 1st bed's dresser second to the last drawer was uneven and the HD opened the drawer and stated that there were overflowing clothes that was why it was uneven and unable to close the drawer. On that same date and time, both S#1 and the HD went inside the [NAME] unit shower room and observed the following: -The 1st cubicle upon entry from the door, the two vents on the ceiling with accumulation of grayish substances which the HD confirmed was accumulation of dust. -The next cubicle with accumulation of dust in the vent. The HD confirmed that it was the housekeeper's responsibility to ensure that the vents were cleaned. Afterward, both S#1 and HD went inside RR#7 and observed behind the window curtains there were two containers of disinfecting sprays with resident name on it. On 8/18/25 at 10:50 AM, the HD called the assigned nurse, and it was the Infection Preventionist/Licensed Practical Nurse (IP/LPN) who came inside RR#7. The IP/LPN and stated that there should be no disinfecting sprays inside the room. On 8/18/25 at 10:55 AM, both S#1 and HD toured East unit and went inside the shower room and observed the vent on the ceiling with accumulation of grayish substances which the HD confirmed accumulation of dust and should have been cleaned. The HD further stated that it was the housekeeper's responsibility to clean the vents in the shower rooms every day. At that same time, S#1 asked the HD if the vents looked like it was cleaned every day and he responded that somewhat not. He also stated that he started as HD July 2025 and to be honest there was no accountability log for cleaning the vents. On 8/19/25 at 2:15 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON), and S#1 notified them of the above findings and concerns. S#1 asked the LNHA and DON who was responsible for RR#11's closet and dresser, and the DON stated the resident's clothes the CNA would be responsible to ensure they were folded. She further stated that it would be the responsibility of the Maintenance to fix dresser and closet. The DON also stated that the disinfecting spray could cause harm to any resident and should be stored properly. S#1 asked (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for a copy of the facility's policy with regard to homelike environment. On 8/21/25 at 11:55 AM, the survey team met with the Regional DON (RDON), LNHA, and the DON. S#2 asked about the facility's homelike environment policy that was asked by S#1, and the LNHA stated that the facility had no policy. 2. On 8/14/25 at 1:02 PM, during the initial tour of the facility, Surveyor #3 (S#3) observed, in RR#29's room, the ceiling directly across from the resident's bed, over the resident's TV (television) and dresser, an area that had some brownish discoloration and a rectangular shaped area that was not the same level or consistency as the rest of the ceiling and appeared that it may be missing a thin section of ceiling material. On 8/18/25 at 12:02 PM, S#3 observed RR#29's room again, with the same area of ceiling as before with no changes. On 8/18/25 at 12:16 PM, S#3 in the presence of the LNHA observed the ceiling area in RR#29s room. The LNHA stated it looks like something came down. S#3 notified the LNHA that they first observed it on 8/14/25. The LNHA stated maintenance may not have gotten to it yet. S#3 asked the LNHA to provide a log or other document stating that it was in process of being repaired and the facility was aware. At that same time, S#3 attempted to locate any maintenance or repair logbook in the nursing station where the resident's room was located. S#3 could not locate any book or documents. On 8/18/25 at 12:23 PM, S#3 asked the Licensed Practical Nurse on the [NAME] unit (LPN-W) how the staff reports any concerns or repair needs to maintenance or other appropriate department. The LPN-W stated that there was an electronic reporting system (ERS) with an app on her phone. The system sends it to the appropriate department, it was time stamped and dated, there was no paper trail that they were aware of. On 8/18/25 at 12:33 PM, S#3 asked the LPN assigned to East wing (LPN-E) how maintenance requests were handled. The LPN-E stated that they call the front desk to get maintenance person to come, they did not use any ERS. On 8/18/25 at 12:40 PM, S#3 asked the Director of Maintenance (DOM) on how they were informed of any repair concerns. The DOM stated that they use the ERS, get a phone call or will get paged. At the same date and time, S#3 observed two maintenance workers come out of RR29's room. The DOM stated that the workers had a printout of maintenance requests but could not show the surveyor any repair order for RR29's room. The DOM also stated that they will fix the ceiling right away. On 8/19/25 at 2:15 PM the survey team met with the LNHA and DON for concerns. S#3 informed the LNHA and DON of the concern with homelike environment for RR#29's room. The LNHA stated that the ceiling was being repaired. S#3 asked the LNHA for any policies for Maintenance or Homelike Environment. On 8/20/25 at 1:06 PM, the survey team met with the LNHA and DON for responses to concerns. The LNHA stated that the ceiling was fixed right away after surveyor's inquiry. The LNHA stated that they had no separate policy for Maintenance or Homelike Environment and that the facility just follows the regulations and use the ERS app on staff phones or computer to address issues. (continued on next page)

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	315525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility did not provide any further pertinent information. NJAC 8:39-31.2(e); 31.4(a)(b)(f)

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	315525	A. Building B. Wing	08/21/2025

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Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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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 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on the interview and record review, it was determined that the facility failed to complete the comprehensive Minimum Data Set (MDS) assessment in accordance with the Resident Assessment Instrument (RAI) manual and facility policy for 2 of 17 (Residents #57 and #62) residents reviewed for comprehensive resident assessments. This deficient practice was evidenced by the following:Reference: Centers For Medicare and Medicaid Services (CMS), RAI manual, Version 3.0, last revised in October 2024, indicated in Chapter 2, pages 2-8 revealed: .admission refers to the date a person enters the facility and is admitted as a resident. A day begins at 12:00 AM and ends at 11:59 PM regardless of whether admission occurs at 12:00 AM or 11:59 PM, this date is considered the 1st day of admission .Under Chapter 2, Section 2.6-Required OBRA [Omnibus Budget Reconciliation Act] Assessments for the MDS revealed:.MDS Completion Date (Item Z0500B) No Later Than. 14th calendar day of the resident's admission (admission date + 13 calendar days) .The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1if.this is the resident's first time in this facility, OR.the resident has been admitted to this facility and was discharged return not anticipated, OR.the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the admission comprehensive assessment at any time prior to the end of day 14.On 8/20/25 at 9:56 AM, the surveyor reviewed the MDS assessments of the following residents which revealed: A review of Resident #62's comprehensive MDS with an Assessment Reference Date (ARD) of 7/30/25, revealed that the MDS was dated and signed as complete on 8/11/25. The resident's date of admission was 7/23/25. The MDS assessment was completed more than 14 days after the admission date.A review of Resident #57's comprehensive MDS with an ARD of 6/1/25, revealed that the MDS was dated and signed as complete on 6/8/25. The resident's date of admission was 5/25/25. The MDS was completed more than 14 days after the admission date.On 8/20/25 at 10:13 AM, the surveyor interviewed the Registered Nurse MDS coordinator (RN/MDSC) over the phone, who stated an comprehensive MDS assessment should be completed within 14 days. The surveyor asked the RN/MDSC if the facility had an MDS policy and if she followed the RAI manual. The RN/MDSC stated would have to get back to the surveyor. The surveyor notified the RN/MDSC about the concern for the late completion for Resident #57 and Resident #62's MDS assessments. The RN/MDSC stated she would review and provide a response to the surveyor.On 8/20/25 at 12:01 PM, the RN/MDSC spoke with the surveyor over the phone. The RN/MDSC acknowledged the identified MDS assessments were completed late. The RN/MDSC confirmed the timeframe to complete the admission MDS assessment was 14 days from the admission date, which was considered day 1. The RN/MDSC stated the facility had an MDS policy and they followed the RAI manual.On 8/20/25 at 1:06 PM, the surveyor notified the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding the concern of late MDS completion for Residents' # 57 and #62.On 8/21/25 at 11:55 AM, the LNHA, the DON, and the Regional DON, met with the survey team. The DON stated in-service education was provided to the social worker and other departments about completing sections of the MDS timely for MDS assessments to be completed and submitted timely. The DON added the facility would initiate a Quality Assurance Performance Improvement (QAPI) project to address the identified concern. A review of the facility's Policy-MDS 3.0 Completion with a reviewed/revised date of 10/1/2024, under Policy Explanation and Compliance Guidelines revealed: admission Assessment- (continued on next page)

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	315525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed within 14 days of admission counting the day of admission as day #1. Required when: i. The resident has no prior admission. Or,ii. Prior admission was less than 14 days AND no admission assessment was completed during the prior admission. Or, iii. Prior admission ended with a Discharge Return not Anticipated; or prior admission ended with a Discharge Return Anticipated AND re-entry occurred > 30 days after the discharge date .NJAC 8:39-11.1, 11.2(e)(h)

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	315525	A. Building B. Wing	08/21/2025

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Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, it was determined that the facility failed to transmit a Minimum Data Set (MDS) assessment, an assessment tool used to facilitate the management of care, within the appropriate timeframe and in accordance with federal guidelines for 3 of 17 residents (Residents #4, #5, and #19), reviewed for resident assessments. This deficient practice was evidenced by the following:Reference: Centers For Medicare and Medicaid Services (CMS), RAI manual, Version 3.0, last revised in October 2024, indicated in Chapter 2, Section 2.6-Required OBRA [Omnibus Budget Reconciliation Act] Assessments for the MDS revealed: .The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1if.this is the resident's first time in this facility, OR.the resident has been admitted to this facility and was discharged return not anticipated, OR.the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge.Federal statute and regulations require that residents are assessed promptly upon admission (but no later than day 14) and the results are used in planning and providing appropriate care to attain or maintain the highest practicable well-being. This means it is imperative for nursing homes to assess a resident upon the individual's admission. The IDT may choose to start and complete the admission comprehensive assessment at any time prior to the end of day 14 .Under Chapter 5, Section 5.2 Timeliness Criteria revealed:.Assessment Transmission: Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date (V0200C2 + 14 days) .On 8/20/25 at 9:03 AM, the surveyor reviewed the MDS assessments of the following residents:A review of system selected Resident #19's comprehensive MDS with an Assessment Reference Date (ARD) of 7/18/25, revealed that the MDS was transmitted on 8/11/25. The MDS assessment was transmitted more than 14 days after the MDS assessment's completion. A review of Resident #4's comprehensive MDS with an ARD of 3/19/25, revealed that the MDS was transmitted on 4/12/25. The MDS assessment was transmitted more than 14 days after the MDS assessment's completion. A review of Resident #5's comprehensive MDS with an ARD of 7/7/25, revealed that the MDS was transmitted on 7/31/25. The MDS assessment was transmitted more than 14 days after the MDS assessment's completion. On 8/20/25 at 10:13 AM, the surveyor interviewed the Registered Nurse MDS coordinator (RN/MDSC) over the phone, who stated a comprehensive MDS assessment should be completed within 14 days, and she would have to get back to the surveyor on the timeframe for the MDS to be transmitted to CMS. The surveyor asked the RN/MDSC if the facility had an MDS policy and if she followed the RAI manual. The RN/MDSC stated she would have to get back to the surveyor. The surveyor informed the RN/MDSC about concern for the late submission of Resident #4, #5, and #19's MDS assessments. The RN/MDSC stated she would review and provide a response to the surveyor. On 8/20/25 at 12:01 PM, the RN/MDSC spoke with the surveyor over the phone. The RN/MDSC acknowledged the identified MDS assessments were late. The RN/MDSC stated the timeframe for the submission of the MDS assessment was from care plan completion plus 14 days. The RN/MDSC stated the facility had an MDS policy and they followed the RAI manual. On 8/20/25 at 1:06 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding the concern of late MDS submission for Residents' # 4, #5, and #19. On 8/21/25 at 11:55 AM, the LNHA, the DON, and the Regional DON, met with the survey team. The DON stated in-service education was provided to the social worker and other departments about completing sections of the MDS timely for MDS assessments to be completed and submitted timely. The DON added the facility would initiate a Quality Assurance Performance Improvement (QAPI) project to address the identified concern. A review of the facility's Policy-MDS 3.0 Completion with a reviewed/revised date of 10/1/2024, under Policy Explanation and Compliance Guidelines revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission Assessment- completed within 14 days of admission counting the day of admission as day #1. Required when: i. The resident has no prior admission. Or,ii. Prior admission was less than 14 days AND no admission assessment was completed during the prior admission. Or, iii. Prior admission ended with a Discharge Return not Anticipated; or prior admission ended with a Discharge Return Anticipated AND re-entry occurred > 30 days after the discharge date .Facility Compliance with Transmission of Assessments a. All applicable completion date time frames must be met in order for the transmission time frames listed below to be applicable and accurate. Any non-adherence to completion deadlines debases the timeline transmission. Both completion and transmission deadlines must be met to be in compliance.NJAC 8:39-11.1, 11.2(e)(h)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. Building B. Wing	08/21/2025

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Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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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 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. Based on observation, interview, and record review, it was determined that the facility failed to; a.) ensure the care plan was updated and monitored the behavior episodes for 1 of 5 residents (Resident #5), b.) ensure rationale for the discontinuation of medication was documented for 1 of 5 residents (Resident #62), reviewed for unnecessary medications, and c.) follow a physician's order for 3 of 17 residents (Residents #5, #24, and #31) reviewed, in accordance with standards of clinical practice. 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 stated, The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, 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. 1.On 8/14/25 at 10:17 AM, Surveyor #1 (S#1) observed Resident #5 asleep in the resident's bed. On 8/14/25 at 1:01 PM, S#1 reviewed Resident #5's medical record. A review of Resident #5's admission Record face sheet (AR, an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; schizoaffective disorder (a mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania), heart failure (a condition where the heart cannot pump enough blood to meet the body's needs), and anemia (a condition in which the blood doesn't have enough healthy red blood cells and hemoglobin, a protein found in red blood cells, to carry oxygen all through the body). A review of Resident #5's admission Minimum Data Set (cMDS), an assessment tool used to facilitate the management of care, with an Assessment Reference Date (ARD) of 7/7/25, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of 6 out of 15, which indicated that Resident #5's cognition was severely impaired. Further review reflected that the resident received an antipsychotic medication (drugs that alter brain chemistry to treat psychotic symptoms like hallucinations, delusions, and disorganized thinking, and to prevent them from recurring). A review of Resident #5's electronic Medication Administration Record/electronic Treatment Administration Record (eMAR/eTAR) included the following order: Risperidone Oral Tablet (tab) Disintegrating 0.5 mg (milligram), give 1 tab by mouth two times a day (2x/day) for Schizophrenia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. Building B. Wing	08/21/2025

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Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #5's Psychiatry Consult dated 7/3/25, reflected under recommendations that the Risperidone was ordered for Schizoaffective disorder. A review of the Consultant Pharmacist's Monthly Report for Resident #5 included the following suggestion: Please clarify and update the diagnosis for Risperdal for schizophrenia. Make sure there is sufficient documentation to support diagnosis. Please review psyc (psychiatric) note March 25. A review of Resident #5's August 2025 eMAR/eTAR included the following order that was changed on 8/5/25: Risperidone Oral Tab Disintegrating 0.5 mg, give 1 tab by mouth 2x/day for Schizoaffective D/O (disorder). A review of Resident #5's comprehensive care plan (CP) included the following focus area: Resident #5 uses psychotropic medications (meds) r/t (related to) Behavior management, Disease process schizophrenia with an initiated date of 7/3/25.The resident's CP was not updated to reflect the corrected diagnosis of schizoaffective disorder for the antipsychotic medication (med) order that was updated on 8/5/25. Further review of Resident #5's August 2025 eMAR/eTAR included the following orders related to behavior monitoring for the antipsychotic med: Behavior & Interventions Monitoring every shift BEHAVIOR(S) EXHIBITED: 0.NONE 1.Agitated 2.Anxious 3.Biting 4.Pacing 5.Crying 6.Screaming/Yelling 7. Hallucinations/Paranoia/Delusions 8.Insomnia 9.Striking out/hitting 10.Withdrawn. The order had a section for the key behavior and nurses initial. The order did not have a section for how many episodes of the behavior the resident exhibited in a shift. Behavior & Interventions Monitoring every shift INTERVENTION(S): 0.NONE 1.Redirect 2.Close Monitoring 3.Activity 4.Toileting 5.Fluids/Food 6.Adjust Environment 7.Change position 8.Massage 9.Medication. The order had a section for the key intervention and nurses initial. A review of Resident #5's Psychotropic Initial Evaluation/Monthly Review with an effective date of 7/31/25, did not indicate the amount of target behaviors exhibited for the month. On 8/19/25 at 10:49 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) regarding behavior monitoring and care plans. LPN #1 stated that behaviors were monitored each shift and would expect to see how many episodes. LPN #1 did not know who calculated the episodes for the monthly report. LPN #1 was not sure who updated the care plan. On 8/19/25 at 11:03 AM, S#1 interviewed the Director of Nursing (DON) regarding behavior monitoring and care plans. The DON stated that there was an order for behavior monitoring in the electronic medical record that was kind of general r/t target behavior. She added that she would look at the eMAR/eTAR to see how many episodes, if any that the resident had for the psychotropic monthly summary which was used related to GDR (gradual drug reduction). S#1 then asked the DON who was responsible for CP updates and how often done. The DON stated that it was usually herself and the Infection Preventionist (IP). The DON stated that updates were done as needed. S#1 showed the DON Resident #5's CP and behavior monitoring order. S#1 asked if the CP should have been updated when (continued on next page)

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Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the indicated diagnosis for the antipsychotic med was changed. The DON stated that the CP should have been updated. S#1 asked the DON if the behavior monitoring order should have how many episodes of the behavior in the shift. The DON stated that the order was lacking the episode part. A review of the undated facility's Interdisciplinary Care Planning Policy and Procedures included the following:Procedure11. Since the CP is a dynamic document, in the interim between quarterly reviews, the IDC (interdisciplinary) team MUST revise problems, goals, and interventions in response to changes in the needs of resident. A review of the facility's Psychoactive Medication Use and GDR Policy dated 10/23, included the following:Policy:It is the policy of this facility to ensure all Residents receiving psychoactive meds are evaluated for a GDR in compliance with regulatory requirements. Policy Statement:To ensure that psychoactive meds are utilized appropriately in compliance with state and federal regulations and to comply with the guidelines related to unnecessary drug use. To comply with regulatory guidelines for the GDR of each psychoactive med class, (including antidepressants).The goal of GDR is to evaluate the need for the med and to determine if the resident is maintained on the lowest possible dose. To maintain resident free from unnecessary meds, as excessive doses, excessive duration, lack of adequate monitoring, lack of adequate indicator for use, or continued use in the presence of adverse consequences.To attempt non-drug interventions and document the outcome in the medical record prior to the use of psychoactive meds whenever clinically appropriate. A review of the facility's Behavior Assessment and Monitoring Policy dated 9/24, included the following:Monitoring1. Exception charting will be used to document the occurrence of any problematic behaviors, interventions implemented, and the resident response to interventions when these behaviors occur. 2. Monthly, behavior monitoring summaries will be completed by nursing that summarizes the occurrence of target behaviors and the effectiveness of interventions.3. For residents with ordered psychoactive meds, information from the monthly summaries along with psychiatric and/or medical re-evaluation will be used to determine if a GDR is feasible or contraindicated as determined by the psychiatrist. 2. A review of Resident #5's August 2025 eTAR included the following:Hydrocortisone External Cream 1% Apply to Right shoulder topically one time a day for rash for 7 Days. The 8/13/25 1100 administration was blank. Assess resident for the following symptoms: fever, cough, shortness of breath, sore throat, headache, muscle aches, vomiting, diarrhea. Document YES if symptoms are noted, notify MD (Medical Doctor) and follow up with a progress note (PN) every shift. The 8/4/25 day shift, 8/5/25 day shift, 8/13/25 day shift and 8/17/25 day shift administrations were blank. Nystop External Powder 100000 UNIT/GM (Nystatin (Topical)) Apply to Right/ Breast topically 2x/day for Redness for 14 Days. The 8/4/25 800 and 1700, 8/5/25 800 and 1700 and 8/13/25 800 and 1700 administrations were blank. Pain assessment to be completed every shift. The 8/4/25, 8/5/25 and 8/13/25 day shift administrations were blank. A review of Resident #24's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; type 2 diabetes mellitus (condition in which the body cannot use insulin correctly and sugar builds up in the blood), hypertension (high blood pressure) and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	osteoporosis (medical condition in which the bones become brittle and fragile from loss of tissue, typically as a result of hormonal changes, or deficiency of calcium or vitamin D). A review of Resident #24's August 2025 eTAR included the following:Cleanse sacral wound with Dakin's apply collagen powder to wound base then calcium alginate. And cover with bordered foam daily and PRN (as needed) every day shift. The 8/7/25 day shift administration was blank. Air mattress every shift for promote wound healing. The 8/7/25 day shift and 8/14/25 night shift administration was blank. Assess resident for the following symptoms: fever, cough, shortness of breath, sore throat, headache, muscle aches, vomiting, diarrhea. Document YES if symptoms are noted, notify MD and follow up with a PN every shift. The 8/7/25 day shift and 8/14/25 night shift administration was blank. Nystatin External Powder 100000 UNIT/GM Apply to Right/ arm topically 2x/day for redness. The 8/6/25 1700 and the 8/7/25 800 and 1700 administration times were blank. Pain assessment to be completed every shift. The 8/7/25 day shift and 8/14/25 night shift administration was blank. A review of Resident #31's AR reflected that the resident was admitted to the facility with diagnoses which included but were not limited to; hypertension, glaucoma (a condition of increased pressure within the eyeball, causing gradual loss of sight), and benign prostatic hyperplasia (age-associated prostate gland enlargement that can cause urination difficulty). A review of Resident #24's August 2025 eTAR included the following:Assess resident for the following symptoms: fever, cough, shortness of breath, sore throat, headache, muscle aches, vomiting, diarrhea. Document YES if symptoms are noted, notify MD and follow up with a progress note every shift. The 8/4/25 day shift, 8/5/25 day shift and 8/13/25 day shift administrations were blank. On 8/19/25 at 10:49 AM, S31 interviewed LPN #1 regarding omissions on the resident's eTAR. LPN #1 stated that if there was an order to be carried out on her shift on the eTAR that it was expected to be done. S#1 showed LPN #1 one of the resident's eTAR that had multiple omissions and LPN #1 stated that there should not be any blanks. On 8/19/25 at 11:03 AM, S#1 interviewed the DON regarding omissions on the resident's eTAR. The DON stated that her expectation would be that there were no omissions. On 8/19/25 at 2:20 PM, S#1 notified the Licensed Nursing Home Administrator (LNHA) and DON the concern that there were omissions on the eTAR for Residents #5, #24, and #31. On 8/20/25 at 1:16 PM, S#1 met with the LNHA and DON for a response to the concern. The LNHA and DON did not have a response. The LNHA and DON did not provide any additional information. A review of the undated facility's Physician Medication Orders Policy did not include information regarding administration and omissions. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.On 8/14/25 at 10:58 AM, S#2 observed Resident #62 in their room, alert, Spanish speaking, verbally responsive, and ambulatory with a cane. The resident did not verbalize any concerns with their care and stated they liked to stay in their room. On 8/18/25 at 9:45 AM, S#2 reviewed the Electronic Medical Record (EMR) of Resident #62. A review of the AR reflected that Resident #62 had diagnoses that included but were not limited to; type 2 diabetes mellitus, hypertension (high blood pressure), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). A review of the cMDS, with an ARD of 7/30/25, reflected a BIMS score of 3 out of 15, which indicated the resident had severe cognitive impairment. A review of the physician's order revealed: Donepezil 5 mg tab, give 1 tab by mouth at bedtime (HS) for dementia. The order was discontinued (d/c'd) on 8/7/25. Seroquel 25 mg tab by mouth OD for Alzheimer's disease was started on 8/7/25 and d/c'd on 8/15/25. The July 2025 eMAR revealed the nurses signed 1 for the donepezil med entry on 7/23/25, 7/24/25, 7/25/25, and 7/30/25, which indicated the resident refused the med. The entries of 7/26/25, 7/27/25, 7/28/25, 7/29/25, and 7/31/25 were signed by the nurses as administered to the resident. The August 2025 eTAR revealed the nurses signed 10 for the donepezil med entry on 8/1/25, which indicated other/see PN. The entries from 8/2/25 to 8/6/25 were signed by the nurses as administered to the resident. A PN dated 8/1/25 at 10:06 PM by the nurse indicated the resident refused all due meds, was verbally aggressive, did not want staff in their room, and the resident was redirected with no success. A PN dated 8/2/25 at 6 PM indicated the resident refused to take their insulin med when offered, raised their cane at staff and threatened to hit the staff. Two different nurses attempted to administer the med to resident at different times and Resident #62 continued to refuse the med; the family and the physician was made aware. Further review of PN in July 2025 and August 2025, revealed the resident refused meds on multiple occasions. A PN dated 8/16/25 note documented Patient received calm in room but disorganized, moving clothes out of drawers and closet. Receptive to redirection. Patient visible on the unit pacing in the hallway with a slow steady gait with the use of cane. Compliant with med after repeated prompting. Refused accucheck despite nursing education. Good appetite. [primary physician] notified. Encouraged patient to sit in day room amongst peers and watch TV (television) however patient refused. Advised patient to verbalize needs/feelings. VS WNL (vital signs within normal limit). Behavior in control. There was no documentation regarding the discontinuation of the resident's seroquel or donepezil med in the PN. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/25 at 11:59 AM, S#2 interviewed LPN #2 who was assigned to care for Resident #62. LPN #2 stated the resident did have a history of refusing med and aggression. LPN#2 explained that she spoke with Resident #62 in Spanish to make them more comfortable, and explained the importance of the med or procedure, such as accucheck, to be administered. LPN #2 stated that the resident was usually cooperative on her shift. S#2 asked LPN #2 about the resident's med of seroquel and donepezil. LPN#2 stated Resident #62 was seen by the psychiatric consultant who recommended to d/c the med and it was. S#2 reviewed with LPN#2 a consult note in the resident's chart. LPN#2 stated the consult was from neurology who recommended the seroquel med to be started. LPN#2 further explained the psychiatric and neurology consultants decided their recommendations and the primary physician d/c'd the meds. S#2 asked LPN#2 where the most recent psychiatric consultant note would be found. LPN #2 was not sure and stated it may be by the other nurses' station. On 8/18/25 12:11 PM, S#2 interviewed LPN #1, who stated the psychiatric consultants left their notes in the resident's hard copy chart or would scan it into the EMR. On 8/18/25 at 12:12 PM, S#2 interviewed the DON, who stated psychiatry consultants uploaded their notes into the miscellaneous section of the EMR. S#2 asked about Resident #62's seroquel med, the DON stated the neurology consultant recommended seroquel for the resident which was started. The DON stated psychiatry was consulted who recommended that the seroquel be d/c'd as the diagnosis and the indication was not appropriate for the resident. S#2 asked the DON about the resident's donepezil med which was also noted as d/c'd. The DON stated the donepezil med was d/c'd as per physician's orders. S#2 asked the DON for the most recent psychiatric consultant note which was not found when reviewing the EMR and the hard copy chart. On 8/19/25 at 1:30 PM, S#2 reviewed the psychiatric consultant note, dated 8/15/25, in the EMR. The note revealed the consultant was requested to evaluate the resident due to the neurology consult recommendation for seroquel. The consultant recommended that the seroquel med be d/c'd, to monitor the resident's mood and behavior, report concerns, to continue donepezil 5 mg by mouth at HS for dementia, and to continue the melatonin supplement (a sleep aid). Further review of EMR did not reveal documentation of why the resident's donepezil was d/c'd. On 8/19/25 at 2:15 PM, S#2 notified the LNHA and the DON about the concern of no documentation regarding why Resident #62's donepezil med was d/c'd and the psychiatric consultant recommending to continue the med. On 8/20/25 at 8:30 AM, the surveyor reviewed the facility provided physician progress note (PPN) with an effective date of 8/19/25, written by the primary physician. The PPN documented the resident was poorly compliant at times with meds and with behavior. The physician indicated the donepezil was d/c'd due to resident non-compliance and that the med was not helping. On 8/20/25 at 8:59 AM, the DON provided the Charting/Documenting Policy to the survey team. On 8/20/25 at 1:06 PM, the LNHA and the DON met with the survey team. The DON stated that the PPN was provided to the surveyor. The DON explained the med was d/c'd by the primary physician as the resident had episodes of refusing the med and it was not helping the resident as much. S#2 asked the DON who received the order from the physician to d/c the donepezil med. The DON replied that (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she was the one who received the order from the physician. S#2 asked the DON if it was expected for staff to document when clarifying orders and recommended meds with the physician. The DON stated it was expected for it to be documented in the EMR. The DON acknowledged there was no additional documentation in the medical records by the nurses or physician regarding the discontinuation of the donepezil med. S#2 requested any policy physician consultants/consultant recommendations. On 8/21/25 at 11:00 AM, the DON informed the surveyors the facility did not have a policy related to physician consultants or their recommendations. A review of the facility's Charting/Documenting Policy, which was undated, revealed under Procedure:.Chart all pertinent changes in the resident/patient/'s condition, reaction to treatment, med, etc., as well as routine observations.Documentation should also include.Any time a physician or family is called about the resident/patent as well as their response.Each time a physician visits the resident/patient and writes orders. NJAC 8:39-27.1(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, it was determined that the facility failed to ensure that a resident receive treatment and care in accordance with professional standards of practice and facility policies and procedures with regard to tube feeding for 1 of 3 residents (Resident #8) reviewed.The 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 registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. 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 8/18/25 at 12:12 PM, the surveyor observed contact precautions signage and personal protective equipment (PPE) by the doorway and a tube feeding (TF) pole in the room. Resident #8 was sitting on a wheelchair watching television.A review of the admission Record (an admission summary) revealed diagnoses which included but not limited to; encounter for surgical aftercare following surgery on the digestive system, cellulitis of abdominal wall, encounter for attention to gastrostomy (opening of the stomach for the introduction of food), CVA (cerebrovascular attack-stroke), NSTEMI (non-ST-segment elevation myocardial infarction-heart attack), hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dysphagia (inability to swallow) following other cerebrovascular disease, CAD (coronary artery disease-narrowing of arteries).A review of the quarterly minimum data set (MDS), an assessment tool which facilitates the plan of care, with an assessment reference date (ARD) of 6/9/25, revealed a brief interview of mental status (BIMS) score of 14 out of 15, indicating intact cognition; and TF was coded.A review of the physician orders revealed the following:Jevity 1.5 via g-tube at 65 ml/hr (milliliters/hour) x 20 hours. Start at 4:00 PM and discontinue (d/c) at 12 PM or until total volume was infused. (Total Volume: 1000 ml) in the evening and remove per schedule, revised 7/17/25.Tube Feeding diet nothing by mouth (NPO) texture, NPO consistency 7/3/25.Check placement of the TF prior to medication (med) administration. Flush tube with a minimum of 30 ml of water at room temperature prior to and immediately after med administration every shift for G- tube placement 6/27/25.Ranolazine ER (extended release-delivers as a gradual dose) Oral Tablet (tab) ER 12 Hour 500 mg (milligram), give 1 tab by mouth every 12 hours for Angina Pectoris (chest pain or discomfort), ordered 5/10/25, end date 5/12/25.Ranolazine ER Oral Tab 12 Hour 500 mg, give 1 tab via G-Tube every 12 hours for Angina Pectoris, ordered 5/12/25, end date 5/14/25.Ranolazine ER Oral Tab 12 Hour 500 mg, give 1 tab by mouth every 12 hours for Angina Pectoris ordered 5/15/25, end date 5/16/25.Ranolazine ER Oral Tab 12 Hour 500 mg, give 1 tab via G-Tube every 12 hours for Angina Pectoris, ordered 5/16/25, end date 6/16/25.Ranolazine ER Oral Tab 12 Hour 500 mg, give 1 tab by mouth every 12 hours for Angina Pectoris, ordered 6/27/5, end date 6/30/25.Ranolazine ER Oral Tab 12 Hour 500 mg, give 1 tab via G-Tube every 12 hours for Angina Pectoris order revised 6/30/25.A review of the med Ranolazine ER manufacturer label for dosage and administration-dosing information reflects, Take Ranexa/Ranolazine with or without meals. Swallow Ranexa tablets whole; do not crush, break, or chew.A review of the resident's care plans revealed: requires enhanced barrier precautions r/t (related to) g-tube Date Initiated: 2/27/25 Created on: 2/27/25 Created by: (Registered Nurse-RN) Revision on: 2/27/25 Revision by: (Registered Nurse). requires TF (JEVITY 1.5) r/t Dysphagia Date Initiated: 5/10/23 Created on: 5/15/23 Created by: (Assistant Director of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing-ADON) Revision on: 6/16/25 Revision by: (Registered Nurse). On 8/19/25 at 12:12 PM, the surveyor interviewed Licensed Practical Nurse #1 (LPN #1), who stated that the resident had dysphagia and stroke in the past, was NPO, did a gastrostomy tube (GT). LPN #1 stated that the resident had an order for Jevity 1.5, the volume was a 1000, on at 4 PM, rate was 65 ml/hr. LPN #1 further stated that meds were crushed via GT. LPN #1 added that med Ranolazine, I know I cannot crush, and I put the pill whole in water in a cup of 5 ml, and dissolved. LPN #1 indicated that there was no other med to administer and that the resident needed the med for resident's angina. LPN #1 confirmed that night shift nurses did the same thing for Ranolazine, dissolved in water in order to administer the med. At that same time, LPN#1 informed the surveyor that we asked pharmacy to change the med and the resident had cardiology appointment. The surveyor asked LPN #1 should there had been a clarification with the cardiologist, and the LPN replied, To be honest, I never called, there should have been a phone call. The primary doctor told me to reach the cardiologist. LPN #1 stated that the resident did not have incident of angina.On 8/19/25 at 12:20 PM, the surveyor reviewed the pharmacy consultant monthly medication review (MMR) from May-August of 2025, and revealed: Recommendations for 5/12/25, #4 Do not crush ranolazine. Please review for an alternative. No action taken.Recommendations for 5/16/25, #8 Do not crush ranolazine. Please review for an alternative. Nurse signature-IP (Infection Preventionist) signed dated 5/17/25.Recommendations for 6/16/25, #16 Do not crush Ranexa. Consider contacting physician for alternatives such as Isordil for angina. Action taken: In the hospital. (Resident was sent to the hospital on 6/18/25).Recommendations for 6/30/25, #4 Do not crush ranolazine. Please review for an alternative. Signed by IP nurse on 7/1/25.Recommendations for 7/15/25, Do not crush Ranexa. Consider alternative for g-Tube administration. No action taken.Recommendations for 8/5/25, Do not crush Ranexa. Consider alternative for G-Tube administration. -Needs cardio f/u.On 8/19/25 at 12:33 PM, the IP Nurse (IPN) informed the surveyor that she contacted the pharmacist to verify if there was a med that equal to Ranexa, and was advised that norvasc was the med that can be used. The IPN further stated that when she called the doctor, the doctor told the IPN that the resident should be seen by the cardiologist for med changes. The IPN was unsure if a cardiology appointment was set up and was unsure as to why there was no cardiology appointment in the resident's chart. The IPN also stated that there should had been a call to the cardiologist to clarify this order.On 8/19/25 at 2:32 PM, the surveyor notified the License Nursing Home Administrator (LNHA) and the Director of Nursing (DON) regarding the concern with ranolazine ER administration. The DON replied that the resident was seen by the cardiologist last year in September, and the recommendation was to follow up in three months. The DON stated that the order should have been clarified. On 8/20/25 at1:07 PM, the survey team met with the LNHA and the DON, and the DON stated that we consulted with the primary doctor (PMD) and the cardiologist after surveyor's inquiry about the concern with ranolazine ER, the resident had no occurrence of angina, and both the PMD and the cardiologist were aware of the manufacturer's information, both decided to continue to administer the med after dissolving to water.A review of the 8/19/25 note, after surveyor inquiry, from the cardiologist, which revealed, Patient has been on Ranexa since developing chest pain on 2/19/2024. It was felt in spite of off label PEG (percutaneous endoscopic gastrostomy-a feeding tube) administration, since it had controlled (patient's) symptoms it should be continued.On 8/21/25 at 11:00 AM, the DON stated to the survey team that the facility did not have a policy on contactor/consultants.NJAC 8.39-27.1(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interview, and review of facility documents, it was determined that the facility failed to a.) provide pharmaceutical services in accordance with professional standards to ensure accurate accountability of controlled substances, have sufficient secure procedures in place to prevent diversion of controlled substances for 1 of 4 residents observed during the medication administration observation and b.) ensure an accurate ordering and receiving of narcotic medications specifically failing to complete the required U.S Official Order Forms Schedules I & II (DEA 222 forms) with sufficient detail to enable accurate reconciliation for 2 of 2 executed forms reviewed and the unexecuted DEA 222 forms were signed by the Medical Director prior to being filled out for 4 of 4 unexecuted forms reviewed. The deficient practice was evidenced by the following: Reference:Title 21 Chapter II Part 1305 Subpart B 1305.13 Procedure for filling DEA Forms 222(e) The purchaser must record on its copy of the DEA Form 222 the number of commercial or bulk containers furnished on each item and the dates on which the containers are received by the purchaser. 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 case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist. 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. 1.On 8/18/25 at 8:36 AM, Surveyor #1 (S#1) began the Medication Administration Observation. S#1 observed the Licensed Practical Nurse (LPN) assigned to the medication (med) cart on the [NAME] Unit prepare to administer due medications (meds) for Resident #7. S#1 observed the LPN remove two meds from the locked drawer containing Controlled Dangerous Substances (CDS) (meds that may have a higher abuse potential and require additional record keeping). The LPN removed and administered Oxycontin (a long-acting med used for pain), and pregabalin (a med used to treat nerve pain) to Resident #7, along with other due meds. S#1 observed the LPN return to the med cart and electronically sign the electronic med administration record (eMAR). S#1 did not observe the LPN sign the CDS Accountability sheet (a log that tracks the number of a particular CDS when removed for administration) for either med before or after they were administered. S#1 observed the LPN move on to the next resident for med administration. S#1 asked the LPN to see the CDS Accountability sheet for Resident #7's OxyContin and pregabalin. The sheets did not reflect that the LPN documented the removal of either dose. S#1 asked the LPN what the usual practice was when CDS meds are removed for administration, and the LPN stated that it should be signed out when removed from the package and before giving to the resident. S#1 completed the med administration observation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315525	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbour View Senior Living Corp	3161 Kennedy Blvd North Bergen, NJ 07047

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	S#1 reviewed the electronic medical record (EMR) for Resident #7 which revealed the following: A review of the admission record (AR, and admission summary), reflected that the resident had diagnoses that included but were not limited to malignant neoplasm of left kidney (cancer of the kidney) and neoplasm related pain (pain related to cancer). A review of the resident's Minimum Data Set (MDS), an assessment tool, with an assessment reference date of (ARD) 7/1/25, reflected a Brief Interview Mental Status (BIMS) score of 14 out of 15, which indicates intact cognition. A review of an Order Summary Report (OSR), reflected that the resident had a current active physician's order (PO) for OxyContin ER (extended release) 12-hour 20 mg (milligram) tablet (tab) and pregabalin 75 mg capsule. On 8/19/25 at 2:15 PM, the survey team met with the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) to discuss the above concerns. S#1 notified the DON of the results of the med-pass observation as well as the concerns with signing the CDS Accountability sheet. On 8/20/25 at 9:39 AM, S#1 interviewed the facility consultant pharmacist (CP) by telephone. S#1 asked the CP how the staff was expected to document the use of CDS. The CP stated that the nurse should sign the CDS Accountability sheet immediately after removing the dose. A review of the undated facility's Medication Administration Policy, revealed that the policy did not reflect any information related to CDS or when to sign for CDS. The facility did not provide any further pertinent information. 2.On 8/18/25 at 9:58 AM, the DON provided S#2 a copy of two executed DEA 222 forms and stated that there were only two DEA 222 forms for the last year. She added that she did not order a lot of narcotics. A review of the executed 222 forms included the following:Order Form: #230236637, dated 7/28/25, revealed no quantity of packages received and no date received of the two meds ordered, which was to be filled in by the purchaser.Order Form: #230236641, dated 8/28/24, revealed no quantity of packages received and no date received of the three meds ordered, which was to be filled in by the purchaser. The facility did not record the number of packages of controlled substances received or the date each med was received as indicated on the instructions for filling out the DEA 222 form. On 8/18/25 at 10:14 AM, S#2 asked the DON the process for the DEA 222 forms. The DON stated that she would fill out the DEA 222 form with the narcotic med that was needed to order and then have the Medical Director (MD) sign the DEA 222 form. She then would fax the DEA 222 form to the pharmacy before mailing it. The pharmacy would then process the order and send the meds. The nurse that received the meds would sign the requisition/declining sheet (not the DEA 222 form) and that requisition/declining sheet was stored with the meds in the back up box. The surveyor asked the DON if the DEA 222 form was filled out when the meds were received. The DON stated that she did not usually fill out the received part on the DEA 222 form. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/25 at 10:26 AM, S#2 requested from the DON to view the unexecuted DEA 222 forms that the facility had. The DON showed the surveyor four unexecuted DEA 222 forms which revealed the following:Order Form: #230236635 had the Medical Director's (MD) signature and the rest of the form was blank. Order Form: #230236642 had the MD's signature and the rest of the form was blank.Order Form: #230236640 had the MD's signature and the rest of the form was blank.Order Form: #230236636 had the MD's signature and the rest of the form was blank.The DON confirmed that the four unexecuted DEA 222 forms were signed by the MD and that they were not filled out with any med orders. On 8/18/25 at 10:32 AM, S#2 asked the DON if the blank DEA 222 forms should be signed by the MD prior to being filled out with a med order. The DON stated that the MD was supposed to sign the DEA 222 forms after the form was filled out with the order. She added that she did not realize they were signed before they were filled out. On 8/19/25 at 2:18 PM, S#2 notified the LNHA and the DON the concern that the executed DEA 222 forms were not completed properly when the controlled meds were received and that the unexecuted DEA 222 forms that were blank (did not contain med order) were signed by the MD. On 8/20/25 at 9:42 AM, S#2 interviewed the CP via telephone, regarding the process for DEA 222 forms. The CP stated that her process was to check the binder that contained the forms. The CP stated that the DON had told her that the binder was not ready so she could not check the facility's binder. The CP stated that she gave the previous DON a checklist which included to make sure there were no pre signed forms. The CP stated that when the med was received the form should be filled out with how many received and attach the receipt. The previous DON had no experience and asked the DON to come back. The surveyor notified the CP about the concerns with the DEA 222 forms. The CP stated that unfortunately she was not able to check the DEA 222 forms. On 8/20/25 at 1:07 PM, in the presence of the LNHA, the DON stated that she had asked the MD to sign the DEA 222 form because she was going to place an order and he was going on vacation. She added that he signed the rest of the DEA 222 forms. The LNHA and DON did not provide any additional information. A review of the facility's 6.0 Controlled Dangerous Substance Inventory for Back Up Box and Emergency Kits Policy with a revised date of September 2020, included the following:Policy.All CDS are dispensed and handled in accordance with state and federal regulations.ProcedureA. CDS Inventory in Back Up Supply-Schedule II CDS(e.g. Demerol, Morphine, Percocet)1. A DEA Form 222 must be completed to obtain the par level quantity of Scheule II CDS in back up supply. Upon signature of the Medical Director or his/her designee, the two copies are sent to the pharmacist in charge at .Pharmacy.A review of the checklist titled BACK-UP CONTROLLED SUBSTANCE CHECKLIST that was provided by the CP included the following:DEA Form 222: When meds arrive from pharmacy, the date received and number of packages received is filled out (part 5).Do not have any pre-signed 222 forms by medical director (use immediately or void & file in order) N.J.A.C. 8:39-29.4(l), 29.7(c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to properly store an ointment and biologicals according to clinical standards of practice. This deficient practice was identified in 1 of 4 Resident Room (Resident room [ROOM NUMBER]) observed during tour of 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 8/18/25 at 10:38 AM, the surveyor with the Housekeeping Director (HD) toured the [NAME] unit and observed Resident room [ROOM NUMBER] (RR#7) behind the window curtain two containers of 91% alcohol and container of zinc oxide ointment skin protectant with resident's name on it. The HD had no answer as to why the alcohol and zinc oxide skin protectant was by the window. On 8/18/25 at 10:50 AM, the HD called the assigned nurse, and it was the Infection Preventionist/Licensed Practical Nurse (IPN/LPN) who came inside RR#7. The IP/LPN stated that the zinc oxide should be stored inside the nurse's treatment cart. The IP/LPN also stated that it was the nurse who administer the zinc oxide, and both the residents inside the room were cognitively impaired. On that same date and time, the surveyor asked why it was important that the containers of alcohol and zinc oxide should be stored properly. The IP/LPN responded in the presence of the HD that it should not be stored inside residents' room for safety. She further stated that it was probably the Resident Representative who brought them. A review of the resident who had their name on zinc oxide container revealed that the resident's order for zinc oxide was discontinued on 8/10/23. On 8/19/25 at 2:15 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the surveyor notified them of the above concerns. The DON stated that it was expected that the zinc oxide be kept in the treatment cart and the alcohol stored in their (resident) respective drawers. She further stated that the alcohol could cause harm to any resident who can grabbed them so they should be stored properly. A review of the facility's Storage of Medications Policy that was provided by the DON, with a revised date of 10/24, revealed that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner.The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.The facility should not use discontinued, outdated, or deteriorated drugs or biologicals.Drugs for external use, as well as poisons, shall be clearly marked as such, and shall be stored separately from other medications.Antiseptics, disinfectants, and germicides used in any aspect of resident care must have legible, distinctive labels that identify the contents and the directions for use, and shall be stored separately from regular medications. NJAC 8:39-29.4(d)(g)(h)