STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061415	A. BUILDING: _____ B. WING _____	C 05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLSVIEW NURSING AND REHABILITATION CENTE	199 POWERVILLE ROAD BOONTON, NJ 07005

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S 000	Initial Comments C #: NJ00160489 Census: 86 Sample Size: 4 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: NJ00160489 Based on interviews, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. This deficient practice was evidence by the following. shifts reviewed.	S 560	PLAN OF CORRECTION: S560 8:39-5.1(a) Mandatory Access to Care □ STATE□S STAFFING RATIOS CORRECTIVE ACTION(S): " Fallsview Rehab and nursing center is actively trying to hire CNAs and train NAs to become CNAs in order to ensure that all shifts are scheduled to comply with ratios.	5/25/23

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

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S 560	Continued From page 1 Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 9/18/22 to 9/24/22, 9/25/22 to 10/1/22, 4/16/23 to 4/22/23, and 4/23/23 to 4/29/23 revealed the staffing to resident ratios did not meet the minimum requirement of 1 CNA to 8 residents for the day shift. The facility was deficient in CNA staffing for 5 of 28 day shifts as follows: -04/16/23 had 8 CNAs for 77 residents on the day shift, required 10 CNAs. -04/22/23 had 9 CNAs for 79 residents on the day	S 560	" DON, staffing coordinator or designee will review staffing callouts daily and make every effort to replace. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE " All residents have the potential to be affected by this situation. MEASURES PUT IN PLACE: " Facility□s Recruitment and Retention Strategies and Efforts to comply with the State□s Staffing Ratios have been in progress, which include but are not limited to the following: o Offer Sign on bonuses to attract staff o Recruitment bonus to encourage referrals from current staff o Facility offers bonuses based on established bonus plan for any extra shifts being picked up by a CNA. o Continue running ads in various social media platform o Flexible shifts and schedules o The facility implemented higher rates for C.N.A□s o Approved agency overtime o Using staffing agencies o Facility conducts job fairs o Nursing staff will assist in covering open C.N.A shifts when needed. o MONITORING OF MEASURES: " Staffing Coordinator or designee will provide weekly reports to the Director of Nursing and Administrator regarding all	

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S 560	Continued From page 2 shift, required 10 CNAs. -04/23/23 had 9 CNAs for 79 residents on the day shift, required 10 CNAs. -04/26/23 had 9 CNAs for 80 residents on the day shift, required 10 CNAs. -04/27/23 had 9 CNAs for 80 residents on the day shift, required 10 CNAs. During the interview with the surveyor on 5/3/23 at 3:45 pm, the Licensed Nursing Home Administrator (LNHA) stated that the facility uses agency staff to fill the staffing needs of the CNAs. She added that they offered incentive for those who work extra hours. The LNHA also stated that she was aware of the new minimum staffing ratio requirements for nursing homes. The SC added that the facility is currently hiring for CNAs. NJAC 8:39-5.1(a)	S 560	efforts made to try to comply with the State□s Staffing Ratios. " Reports will be submitted to the QAPI Committee monthly X 3 months. " After 3 months QAPI Committee will review if any further changes have to b	

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F 000	INITIAL COMMENTS C #: NJ00160489 Census: 86 Sample Size: 4 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities, based on this complaint survey.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		5/25/23

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

Electronically Signed | 05/23/2023

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F 842	Continued From page 1	F 842		

records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 2 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: C #: NJ 160489 Based on interviews, medical record review, and review of other pertinent facility documents on 5/3/23, it was determined that the facility staff failed to consistently document in the "Documentation Survey Report" (DSR) the Activities of Daily Living (ADL) status and care provided to the resident according to facility policy and protocol for 2 of 4 residents (Resident #1 and Resident #2) reviewed for documentation. This deficient practice was evidenced by the following: Review of a facility policy titled "Charting and Documentation", dated 1/2022, reflected "Policy Statement All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record ...1. Documentation in the medical record may be electronic, manual or a combination ...2 ...c. Treatments or services performed ...3. Documentation in the medical record will be objective ...complete, and accurate ...5. a. The date and time the procedure/treatment was provided ...e. Whether the resident refused the procedure/treatment ..." 1. According to the facility "Admission Record (AR)," Resident #1 was admitted on [redacted] with diagnoses that included but were not limited to: [redacted]	F 842	F842 Medical Records Resident Records - Identifiable Information 1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident #1 and Resident #2 were affected by the practice. " In-services initiated and will continue to provide in-services to C.N.A. on Policy and Procedure regarding completion of ADL documentation. In-services will also stress the importance of documentation. 2. How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: " All residents have potential to be affected by the same practice and corrective action will be taken as follows systemwide. " Daily auditing of documentation compliance from previous 24 hours, follow up with staff who have missed documentation. " Scheduler to ensure every agency employee has POC login and trained to document care before their shift " C.N.A designee as mentor /lead to assist/encourage all C.N.A.s to complete POC.	

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F 842	Continued From page 3 The Minimum Data Set (MDS), an assessment tool, dated EX. Order 26.(4) B1 revealed a Brief Interview of Mental Status (BIMS) of EX. O which indicated the resident's EX. Order 26.(4) B1 and the resident needed assistance with activities of daily living (ADLs) including toileting. A Care Plan (CP), initiated on EX. Order 26.(4) B included that the Resident had a self-care performance deficit and was EX. Order 26.(4) B1. Interventions included but were not limited to: the resident needed assistance from staff for toileting. Review of Resident #1's DSR (ADL Record) and the progress notes (PN) for the month of EX. Order 26.(4 and EX. Order 26.(4, lack any documentation to indicate that the care for toileting was provided and/or the resident refused care on the following dates and shifts; 7:00 am-3:00 pm shift on 3/2/23, 3/4/23, 3/6/23, 3/8/23 to 3/12/23, 3/14/23, 3/19/23, 3/21/23, 3/25/23, 4/10/23, 4/11/23, 4/13/23, 4/21/23, 4/24/23, 4/25/23, and 4/27/23 to 4/29/23. 3:00 pm-11:00 pm shift on 3/2/23 to 3/14/23, 3/16/23, 3/18/23 to 3/21/23, 3/23/23 to 3/28/23, 3/30/23, 4/1/23, 4/3/23 to 4/7/23, 4/10/23 to 4/22/23, and 4/24/23 to 4/30/23. 11:00 pm-7:00 am shift on 3/1/23, 3/2/23, 3/5/23, 3/6/23, 3/8/23 to 3/20/23, 3/22/23, 3/27/23, 3/30/23, 4/6/23, 4/8/23, 4/10/23, 4/13/23, 4/14/23, 4/23/23, 4/24/23, and 4/27/23. 2. According to the facility AR, Resident #2 was admitted on EX. Order 26.(4), with diagnosis that included but was not limited to: EX. Order 26.(4) B1 and EX. Order 26.(4) B1.	F 842	3. What measures will be put into place or what systemic changes you will make to ensure that the practice does not recur: " Daily auditing of documentation compliance from previous 24 hours, follow up with staff who have missed documentation. " Scheduler to ensure every agency employee has POC login and trained to document care before their shift " C.N.A designee as mentor /lead to assist/encourage all C.N.A.s to complete POC. . 4. How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: " The admin will conduct a weekly review X 4 weeks and present weekly reports. " The admin will conduct audits then every 2 weeks X 2 months " Findings of these reviews will be presented at the monthly QAPI meeting until such time as the committee determines substantial compliance has been achieved.	

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F 842	Continued From page 4 The MDS, dated EX. Order 26.(4), revealed a BIMS of EX. O which indicated the resident's EX. Order 26.(4) B1 and the resident needed extensive assistance with ADLs. The CP, dated EX. Order 26.(4) B, included that Resident #2 was EX. Order 26.(4) B1 and EX. Order 26.(4). Interventions included but were not limited to: the resident needed assistance from staff for toileting. Review of Resident #2's DSR and PN for the month of EX. Order 26.(4), lacked documentation that the care was provided and/or the resident refused care for toileting on the following dates and shifts; 7:00 am-3:00 pm shift on 9/12/22, 9/17/22, 9/26/22, and 9/28/22. 3:00 pm-11:00 pm shift on 9/12/22 to 9/14/22, 9/17/22, 9/18/22, 9/21/22, 9/24/22, 9/27/22. 11:00 pm-7:00 am shift on 9/12/22 to 9/15/22, 9/18/22, 9/25/22, and 9/26/22. During an interview with the surveyor on 5/3/23 at 10:46 am and 1:28 pm, Certified Nursing Assistant (CNA #1), who took care of Resident #1 during 7:00 am to 3:00 pm shift, stated that CNAs are responsible for documenting the ADL care provided into the Point of Care (is a mobile-enabled app that runs on wall-mounted kiosks or mobile devices that enables care staff to document activities of daily living at or near the point of care to help improve accuracy and timeliness of documentation). CNA #1 further stated that he would document even if the care was not provided due to refusal. He explained that the documentation must be completed in the residents DSR by the end of each shift to show that the care was provided to the residents. CNA	F 842		

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F 842	Continued From page 5	F 842		

#1 could not explain why there were blanks in the sampled resident's DSR but stated that it should have been completed.

During an interview with the surveyor on 5/3/23 at 10:57 am, Licensed Practical Nurse (LPN #1) stated that the CNA's were expected to document ADL care provided to the resident by the end of the shift in the DSR. She explained that Nurses and the Unit Managers (UM) were to check the documentation to ensure that the DSR is completed at the end of the shift. LPN #1 could not explain why there were blanks in the resident's DSR but stated that they should have been completed to show that the care was/was not provided from the CNAs.

During a post survey telephone interview with the surveyor on 5/5/23 at 1:32 pm, Unit Manager LPN #2 (UM/LPN #2) stated she made sure that the ADLs were provided to all residents. She also stated that CNAs were expected to document in the DSR at the end of their shift what kind of care was provided to the residents. The UM/LPN #2 revealed that she was not familiar with the software and was unable to check if the CNAs were completing their documentation in the Point of Care/DSR.

During a post survey telephone interview with the surveyor on 5/5/23 at 1:45 pm, the Director of Nursing (DON) stated that the CNAs were expected to document the care provided to the residents in the DSR at the end of the shift. She further stated that she was not aware that the CNAs documentations were not completed regularly, and that the UM/LPN #2 was not familiar with the software. The DON further stated that the there was an appointed "Charge Aide"

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F 842	Continued From page 6 (CA), who was responsible of overseeing the DSR to ensure that the DSR were completed, however, the CA was on leave for personal reason. The DON stated that the nurses and UM were to check and make sure that the DSR are completed. Review of the job description titled "Certified Nursing Assistant", dated 9/1/19, indicated "...Document in the nursing assistant notes the care and treatment provided to the resident and the resident's response or lack of response to care provided...Complete documentation accurately, timely and following facility policies and procedures..." NJAC 8:39-35.2(d)(9)	F 842		