STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONTON CARE CENTER	**199 POWERVILLE ROAD BOONTON, NJ 07005**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS COMPLAINT#: NJ 135828 Census: 52 Sample: 5 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON VISIT.	F 000		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Complaint # NJ 135828 Based on observation and interview on 10/2/2020, in the presence of Facility Management, it was determined that the facility failed to maintain resident rooms in good condition, and provide a hazard free environment for 1 of 7 resident rooms reviewed. This deficient practice was evident by the following: At 10:45 a.m., in the presence of the Building Services Director (BSD) and the Maintenance Director (MD), a tour of the building was conducted. This tour included inspection of the 1st. floor common corridors, shower room, Beauty salon, Resident Dining room, 4 Activity/ Lounge areas, and 7 Resident rooms with the	F 921	I. Immediate Corrective Action 1. Toilet was immediately repaired by facility maintenance personnel. 2. In-Service was provided to the maintenance director and staff. II. Identification of Other Residents 1. Residents were involved with this deficiency; however, no residents were directly affected. III. Systemic Changes 1. Director of Maintenance and maintenance staff toured the entire facility and inspected to ensure all toilets were	10/26/20

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

Electronically Signed | 10/26/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	C 10/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONTON CARE CENTER	**199 POWERVILLE ROAD BOONTON, NJ 07005**

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F 921	Continued From page 1 following was observed: 1. At 11:39 a.m., the surveyor observed inside sampled resident # 4's bathroom, that when the toilet was flushed, the toilet rocked and moved backwards. The surveyor observed the front of the toilet lifted 1/4 of an inch off the floor. At this time the MD said, the bolts on the bottom must have broken. The toilet was loose and not secured to the floor. Later the MD told the surveyor that the toilet had plastic bolts installed to hold the toilet to the floor plumbing flange. NJAC 8:39 -31.2 (e).	F 921	installed per manufacturer recommendations and meet the requirements of providing a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 2. Audit tool was created for continued monitoring weekly for 30 days. IV. QA Monitoring 1. Findings will be reported to the QA Committee on a quarterly basis. V. Date of Correction and Responsible Party 1. Director of Maintenance and maintenance staff has ensured ongoing compliance.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315492 Y1	A. Building B. Wing Y2	10/30/2020 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONTON CARE CENTER	199 POWERVILLE ROAD BOONTON, NJ 07005

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0921 Reg. # 483.90(i) LSC	Correction Completed 10/26/2020	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
10/2/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO