

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

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315492	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/02/2024
NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 #s: NJ175578, NJ170736, NJ166580 Survey Dates: 09/25/2024 through 10/02/2024 Census: 90 Sample Size: 18 + 2 closed records A Recertification survey was conducted to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facility. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000			
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to accurately reflect the resident status in the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care in accordance with the federal guidelines for one (1) of 18 residents (Resident #71) reviewed for the accuracy of MDS coding. This deficient practice was evidenced by the following: On 09/25/24 at 11:05 AM, the surveyor observed Resident #71 seated in bed with NJ Ex Order 26.4(b)(1)	F 641	1. The assessment for Resident #71 was immediately corrected. 2. All residents are at risk of being affected by this deficient practice. 3. U.S. FOIA (b) (6) was in-service by Administrator on 10/21/24 regarding proper coding. 4. Regional MDS Coordinator or designee will audit 3 charts a month for 3 months for accurate coding of bowel and bladder appliances and vaccination status, and results will be brought to the quarterly Quality Assurance Performance Improvement meeting.		11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/27/2024

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.

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F 641	<p>Continued From page 1</p> <p>NJ Ex Order 26.4(b) NJ Ex Order 26.4(b)(1)</p> <p>inside a NJ Ex Order 26.4(b)(1), NJ Ex Order 26.4(b)(1)</p> <p>. The resident was able to respond to surveyor's inquiry.</p> <p>On 09/30/24 at 09:35 AM, the surveyor reviewed Resident #71's electronic medical record, which revealed the following information:</p> <p>The resident's Admission Record (an admission summary) (AR) documented that Resident #71 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1).</p> <p>The Admission MDS (A/MDS), dated NJ Ex Order 26.4(b)(1) indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of NJ Ex Order 26.4(b)(1) out of 15, which stated that the resident had NJ Ex Order 26.4(b)(1). Further review of the A/MDS "Section NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1)" was coded NJ Ex Order 26.4(b)(1).</p> <p>A review of the Order Summary Report from NJ Ex Order 26.4(b)(1) does not reflect NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1).</p> <p>A review of Resident #71's person-centered interdisciplinary care plan does not reflect that the resident had a NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) or NJ Ex Order 26.4(b)(1).</p> <p>A review of the Physician's Progress Notes (PPN)</p>	F 641			

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F 641	<p>Continued From page 2</p> <p>dated [REDACTED] does not reveal the resident had a [REDACTED] or [REDACTED] in the assessment.</p> <p>A review of nursing progress notes from [REDACTED] to [REDACTED] did not reflect documentation that the resident has a [REDACTED] or [REDACTED].</p> <p>On 09/30/24 at 10:55 AM, the surveyor interviewed the [REDACTED] U.S. FOIA (b) (6) [REDACTED] who stated it was a coding error when she indicated that the resident had [REDACTED]. The [REDACTED] U.S. FOIA (b) (6) [REDACTED] also added that the resident had no previous history of presence of [REDACTED] documentation in the medical records.</p> <p>According to the CMS (Centers for Medicare & Medicaid Services) MDS 3.0 RAI (Resident Assessment Instrument) Manual of October 2024, The RAI manual revealed under Version 3.0 Manual, page H-3, under "H0100: Appliances (Cont.)" [REDACTED] NJ Ex Order 26.4(b)(1) and [REDACTED] NJ Ex Order 26.4(b)(1) should be coded as an [REDACTED] NJ Ex Order 26.4(b)(1) only, not as an [REDACTED] NJ Ex Order 26.4(b)(1)."</p> <p>Further review of the A/MDS, dated [REDACTED] NJ Ex Order 26.4(b)(1), revealed under "Section [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] A. Did the resident receive the [REDACTED] NJ Ex Order 26.4(b)(1) in this facility for this year's [REDACTED] NJ Ex Order 26.4(b)(1) season? Was coded " [REDACTED] NJ Ex Order 26.4(b)(1) C. If [REDACTED] NJ Ex Order 26.4(b)(1) not received, state reason:" and was coded " [REDACTED] NJ Ex Order 26.4(b)(1) " And "Section [REDACTED] NJ Ex Order 26.4(b)(1) [REDACTED] A. Is the resident's [REDACTED] NJ Ex Order 26.4(b)(1) up to date?" was coded " [REDACTED] NJ Ex Order 26.4(b)(1) " C. If [REDACTED] NJ Ex Order 26.4(b)(1) not received, state reason:" and was coded " [REDACTED] NJ Ex Order 26.4(b)(1) ".</p>	F 641			

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F 641	<p>Continued From page 3</p> <p>On 09/25/24 at 11:05 AM, the surveyor interviewed Resident #71, who stated that they received the NJ Ex Order 26.4(b)(1) yearly but could not recall the date when he received the NJ Ex Order 26.4(b)(1).</p> <p>On 09/30/24 at 11:53 AM, the surveyor interviewed the facility's U.S. FOIA (b) (6). The U.S. stated that Resident #71 had history of receiving NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1) U.S. years ago. The U.S. also stated they obtained a consent from the resident to receive the NJ Ex Order 26.4(b)(1). The resident refused to get a NJ Ex Order 26.4(b)(1).</p> <p>A review of the NJ Ex Order 26.4(b)(1) record revealed the following: "PCV-20 Consent Required, NJ Ex Order 26.4(b)(1) Consent Required, NJ Ex Order 26.4(b)(1) Consent Required."</p> <p>On 09/30/24 at 10:55 AM, the surveyor interviewed the U.S. FOIA (b) (6), who stated that one of the processes of gathering assessment was through interview of the resident or family members. The U.S. FOIA (b) (6) also stated that she does not remember why the data was "not assessed" or "no information" for both NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1). The (b) (9) stated they followed the RAI Manual.</p> <p>According to the CMS (Centers for Medicare & Medicaid Services) MDS 3.0 RAI Manual of October 2024, The RAI manual revealed under Version 3.0 Manual, page O-12, under NJ Ex Order 26.4(b)(1). Steps for assessment 2. Ask the resident if they received an NJ Ex Order 26.4(b)(1) outside the facility for this year's NJ Ex Order 26.4(b)(1) season. If NJ Ex Order 26.4(b)(1) status is still</p>	F 641			

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F 641	Continued From page 4 unknown, proceed to the next step." On page O-16, under 'NJ Ex Order 26.4(b)(1)'. Steps for assessment 2. Ask the resident if they received any NJ Ex Order 26.4(b)(1) outside of the facility. If the NJ Ex Order 26.4(b)(1) status is still unknown, proceed to the next step." On 10/01/24 at 09:57 AM, the survey team met with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6) to discuss the above concerns. There was no further information provided.	F 641			
F 656 SS=D	NJAC 8:39-33.2(c)2, (d) Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656			11/8/24

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F 656	<p>Continued From page 5</p> <p>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to develop and implement a comprehensive person-centered care plan (CP) for one (1) of 18 residents (Resident #75) reviewed for comprehensive person-centered CP.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 09/25/24, at 10:20 AM, the surveyor observed Resident #75 in their room seated in bed wearing a [NJ Ex Order 26.4(b)(1)] (NJ Ex Order 26.4(b)(1))</p>	F 656	<p>1. The care plan for Resident #75 was immediately corrected.</p> <p>2. Residents receiving [NJ Ex Order 26.4] and / or restorative nursing programs are at risk of being affected by this deficient practice.</p> <p>3. Nursing Managers in-serviced by Administrator on 10/21/24 regarding ensuring accurate person-centered care plans that reflect treatments and services ordered for the resident.</p> <p>4. DIRECTOR OF NURSING (Director of Nursing) or designee will audit 3 charts a month for 3 months, results will be</p>		

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F 656	<p>Continued From page 6</p> <p>NJ Ex Order 26.4(b)(1) connected to an NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1) which reflected on the NJ Ex Order 26.4(b)(1).</p> <p>On 09/26/24 at 10:19 AM, the surveyor reviewed Resident #75's electronic medical record, which revealed the following information:</p> <p>The resident's Admission Record (an admission summary) revealed that Resident #75 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1).</p> <p>The Quarterly Minimum Data Set (Q/MDS), dated NJ Ex Order 26.4(b)(1), indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status score of NJ Ex out of 15, which indicated that the resident was NJ Ex Order 26.4(b)(1). Further review of the Q/MDS under "Section NJ Ex Special Treatments, Procedures, and Programs NJ Ex Order 26.4(b)(1) B. While a Resident" was coded NJ Ex Order 26.4(b)(1).</p> <p>A review of the NJ Ex Order 26.4(b)(1) Order Summary Report (OSR) revealed the following Physician's Order (PO) dated NJ Ex Order 26.4(b)(1) for NJ Ex Order 26.4(b)(1) every shift. Further review of the NJ Ex Order 26.4(b)(1) OSR revealed a PO for NJ Ex Order 26.4(b)(1) dated NJ Ex Order 26.4(b)(1) to perform NJ Ex Order 26.4(b)(1) to NJ Ex Order 26.4(b)(1) as tolerated.</p> <p>The above PO for NJ Ex Order 26.4(b)(1) was transcribed to the NJ Ex Order 26.4(b)(1) electronic Medication Administration Record and was</p>	F 656	brought to the quarterly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meeting.		

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F 656	<p>Continued From page 7</p> <p>signed by the nurses which indicated that the [REDACTED] was administered to the resident every shift.</p> <p>A review of Resident #75's comprehensive person-centered CP did not reflect the resident's use of [REDACTED] for the [REDACTED]</p> <p>On 10/01/24 at 09:40 AM, the surveyor interviewed the [REDACTED], who confirmed that the resident had a PO for [REDACTED] to [REDACTED]</p> <p>On 10/01/24 at 09:57 AM, the surveyor team met with the [REDACTED] and the [REDACTED] to discuss the above concern. There was no further information provided.</p> <p>A review of the facility policy titled "Care Plans, Comprehensive, Person-Centered" with a revision date of 1/2024 reflected under: "Policy Statement, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident." Under "Policy Interpretation and Implementation, k. Reflect treatment goals, timetables, and objectives in measurable outcomes; m. Aid in preventing or reducing decline in the resident's functional status and/or functional levels; n. Enhance the optimal functioning of the resident by focusing on a rehabilitative program."</p> <p>NJAC 8:39-11.2(e) thru (i); 27.1(a)</p>	F 656			

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F 695 SS=D	<p>Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to administer NJ Ex Order 26.4(b)(1) according to the physician's order for 2 of 2 residents (Resident #30 and #75) reviewed for NJ Ex Order 26.4(b)(1)</p> <p>This deficient practice was evidenced by the following:</p> <p>1. On 09/25/24 at 11:35 AM and on 09/26/24 at 11:30 AM, the surveyor observed on both days that Resident #30 was lying in bed, wearing a NJ Ex Order 26.4(b)(1)</p> <p>NJ Ex Order 26.4(b)(1) connected to an NJ Ex Order 26.4(b)(1) at NJ Ex Order 26.4(b)(1) on the NJ Ex Order 26.4(b)(1)</p> <p>On 09/25/24 at 12:01 PM, the surveyor reviewed Resident #30's electronic medical record, which revealed the following information:</p> <p>The resident's Admission Record (an admission summary) (AR) documented that Resident #30 was admitted with diagnoses that included but were not limited to NJ Ex Order 26.4(b)(1)</p>	F 695	<p>1. The settings on the NJ Ex Order 26.4(b)(1) were immediately adjusted for Residents #30 and #75 to reflect the ordered NJ Ex Order 26.4(b)(1)</p> <p>2. All residents on oxygen are at risk of being affected by this deficient practice.</p> <p>3. All nursing staff were in-serviced by the DIRECTOR OF NURSING on 10/21/24 regarding oxygen settings following the physician's order.</p> <p>4. DIRECTOR OF NURSING or designee will audit 3 charts for 3 months, results will be brought to the quarterly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meeting.</p>		11/8/24

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F 695	<p>Continued From page 9 (NJ Ex Order 26.4(b)(1)).</p> <p>The Annual Minimum Data Set (A/MDS), an assessment tool used to facilitate the management of care dated (NJ Ex Order 26.4(b)(1)) indicated that the facility assessed the residents' cognitive status using a Brief Interview for Mental Status (BIMS) score of (NJ Ex Order 26.4(b)(1)) out of 15, which indicated that the resident had (NJ Ex Order 26.4(b)(1)). Further review of the A/MDS "Section (NJ Ex Order 26.4(b)(1)) Special Treatments, Procedures, and Programs (NJ Ex Order 26.4(b)(1)) B. While a Resident" was coded (NJ Ex Order 26.4(b)(1)).</p> <p>A review of the (NJ Ex Order 26.4(b)(1)) Order Summary Report (OSR) revealed an active Physician Order (PO) with an order date of (NJ Ex Order 26.4(b)(1)) for (NJ Ex Order 26.4(b)(1)) every shift.</p> <p>The above PO for (NJ Ex Order 26.4(b)(1)) was transcribed to the (NJ Ex Order 26.4(b)(1)) electronic Treatment Administration Record (eTAR) and was signed by nurses indicating (NJ Ex Order 26.4(b)(1)) was administered to Resident #30 every shift.</p> <p>On 09/26/24 at 12:17 PM, the surveyor in the presence of the (U.S. FOIA (b) (6)) checked and confirmed that the (NJ Ex Order 26.4(b)(1)) was (NJ Ex Order 26.4(b)(1)) from the (NJ Ex Order 26.4(b)(1)). The (U.S. FOIA (b) (6)) checked the eTAR and confirmed to the surveyor that the (NJ Ex Order 26.4(b)(1)) PO was at (NJ Ex Order 26.4(b)(1)).</p> <p>2. On 09/25/24, at 10:20 AM, the surveyor observed Resident #75 inside their room seated in bed wearing (NJ Ex Order 26.4(b)(1)) set on the (NJ Ex Order 26.4(b)(1)).</p>	F 695			

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F 695	<p>Continued From page 10</p> <p>On 09/26/24 at 12:25 PM, the surveyor observed Resident #75 seated in a wheelchair inside the dining room having their lunch. The surveyor observed Resident #75 receiving [NJ Ex Order 26.4(b)(1)] connected to a [NJ Ex Order 26.4(b)(1)]. The LPN confirmed to the surveyor that the resident was receiving [NJ Ex Order 26.4(b)(1)].</p> <p>On 09/26/24 at 10:19 AM, the surveyor reviewed Resident #75's electronic medical record, which revealed the following information:</p> <p>The resident's AR documented that Resident #75 was admitted with diagnoses that included but were not limited to [NJ Ex Order 26.4(b)(1)] [NJ Ex Order 26.4(b)(1)].</p> <p>The Quarterly Minimum Data Set (Q/MDS), dated [NJ Ex Order 26.4(b)(1)], indicated that the facility assessed the residents' [NJ Ex Order 26.4(b)(1)] using a BIMS score of [NJ Ex Order 26.4(b)(1)] out of 15, which reflected that the resident was [NJ Ex Order 26.4(b)(1)]. Further review of the Q/MDS "Section [NJ Ex Order 26.4(b)(1)] Special Treatments, Procedures, and Programs [NJ Ex Order 26.4(b)(1)] B. While a Resident" was coded [NJ Ex Order 26.4(b)(1)].</p> <p>A review of the [NJ Ex Order 26.4(b)(1)] OSR revealed an active PO with an order date of [NJ Ex Order 26.4(b)(1)] for [NJ Ex Order 26.4(b)(1)] every shift.</p> <p>The above PO for [NJ Ex Order 26.4(b)(1)] was transcribed to the [NJ Ex Order 26.4(b)(1)] electronic Medication Administration Record (eMAR) and was signed by nurses as administered every shift.</p> <p>On 10/01/24 at 09:57 AM, the survey team met with the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)]. There were no further</p>	F 695			

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F 695	Continued From page 11 information provided. The facility policy titled "Oxygen Administration" with a revision date of 1/2024 under "Preparation. 1. Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration."	F 695			
F 755 SS=D	NJAC 8:39-25.2(c) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755			11/8/24

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F 755	<p>Continued From page 12</p> <p>receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to ensure that a medication was administered according to the physician orders (PO) and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice was identified in 1 (one) of 4 (four) residents (Resident #61) observed during the medication observation pass.</p> <p>The deficient practice was evidenced by the following:</p> <p>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."</p> <p>Reference: New Jersey Statutes Annotated, Title 45, Chapter 11, Nursing Board. The Nurse Practice Act for the State of New Jersey states:</p>	F 755	<ol style="list-style-type: none"> 1. Physician of Resident #61 was notified and no new orders were given. 2. All residents are at risk of being affected by this deficient practice. 3. All Nurses were in-serviced by the DIRECTOR OF NURSING on 10/21/24 on correct medication administration. 4. DIRECTOR OF NURSING or designee will audit 2 medication pass observations for 2 nurses to ensure proper medication administration, each month, for 3 months. Results will be brought to the quarterly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meeting. 		

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F 755	<p>Continued From page 14</p> <p>A review of the Admission Record (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included but not limited to NJ Ex Order 26.4(b)(1) [REDACTED], NJ Ex Order 26.4(b)(1) [REDACTED], and NJ Ex Order 26.4(b)(1) [REDACTED].</p> <p>A review of the Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4(b)(1) [REDACTED], reflected that the resident's NJ Exec Order 26.4b1 [REDACTED] for daily NJ Exec Order 26.4b1 [REDACTED] score was NJ Ex [REDACTED] out of 15, which indicated that the resident's NJ Ex Order 26.4b1 [REDACTED] was NJ Ex Order 26.4(b)(1) [REDACTED].</p> <p>A review of the NJ Ex Order 26.4(b)(1) [REDACTED] Order Summary Report (OSR) revealed a PO dated NJ Ex Order 26.4(b)(1) [REDACTED], for NJ Ex Order 26.4(b)(1) [REDACTED] give 1 capsule by mouth two times a day for NJ Ex Order 26.4(b)(1) [REDACTED]. Administer 30 minutes after meal. Do Not Crush, open or chew. Swallow capsules whole with water.</p> <p>A review of the NJ Ex Order 26.4(b)(1) [REDACTED] electronic Medication Administration Record (eMAR) revealed an order dated NJ Ex Order 26.4(b)(1) [REDACTED], for NJ Ex Order 26.4(b)(1) [REDACTED] give 1 capsule by mouth two times a day for NJ Ex Order 26.4(b)(1) [REDACTED]. Administer 3 minutes after meal. Do Not Crush, open or chew. Swallow capsule whole with water.</p> <p>On 9/30/24 at 11:45 AM, the surveyor in the presence of LPN #1 reviewed Resident #61's</p>	F 755			

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F 755	Continued From page 15 physician's orders. After reviewing the resident's PO for [REDACTED] the surveyor interviewed LPN #1, who acknowledged that the resident's [REDACTED] should have not been opened and that she should have administered the medication whole with water. On 9/30/24 at 1:30 PM, the surveyor discussed the above concern with the [REDACTED] U.S. FOIA (b) (6) [REDACTED] and [REDACTED] U.S. FOIA (b) (6) [REDACTED]. There was no additional information provided. A review of the facility's policy for "Administering Medication" dated 6/19/23, which was provided by the [REDACTED] U.S. FOIA (b) (6) included the following: "Medications must be administered in accordance with the orders, including the required time frames." NJAC 8:39-11.2 (b), 29.2 (d) Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 755			
F 761 SS=D		F 761			11/8/24

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F 761	<p>Continued From page 16 personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store, and dispose of medications in two (2) of four (4) medication carts inspected.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 10/1/24 at 10:15 AM, the surveyor inspected the first-floor medication cart #2 in the presence of a Licensed Practical Nurse (LPN#1). The surveyor observed an opened vial of Lantus insulin with an opened date of 8/24/24 and was expired.</p> <p>At that time, the surveyor interviewed LPN#1 who acknowledged that Lantus Insulin vial which was opened on 8/24/24 and was expired. She stated to the surveyor that Lantus insulin once opened had a 28-day expiration date.</p> <p>On 10/1/24 at 10:25 AM, the surveyor inspected the 1st floor medication cart #1 in the presence of LPN#2. The surveyor observed an unopened bottle of Xalatan eye drops (medication for</p>	F 761	<p>1. The expired medications were immediately discarded; the unopened box of Xalatan eye drops was immediately placed in the refrigerator.</p> <p>2. All residents are at risk of being affected by this deficient practice.</p> <p>3. All nurses were in-serviced by the Administrator on 10/21/24 regarding proper medication storage practices.</p> <p>4. DIRECTOR OF NURSING or designee will audit 2 medication storage areas a month for 3 months, results will be brought to the quarterly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meeting.</p>		

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F 761	<p>Continued From page 17</p> <p>pressure in the eye) that was not dated and was stored in the medication cart and an opened vial of Lantus insulin that contained no opened date.</p> <p>At that time, the surveyor interviewed LPN#2 who acknowledged that the opened bottle of Xalatan eye drops should have been stored in the medication refrigerator. LPN #2 also acknowledged that once the Lantus insulin was removed from the refrigerator, it should have been dated.</p> <p>On 10/1/24 at 11:45 AM, the surveyor inspected the 2nd floor medication cart #2 in the presence of LPN#3. The surveyor observed an opened bottle of Timolol eye drops (medication for pressure in the eye) that was dated 8/24/24 and was expired.</p> <p>At that time, the surveyor interviewed LPN#3 who stated that the Timolol eye drops were expired and that it should have been removed from the medication cart.</p> <p>A review of the Manufacturer's Specifications for the following medications revealed the following:</p> <ol style="list-style-type: none"> 1. Lantus insulin vial once opened has an expiration date of 28-days. 2. Unopened Xalatan eye drops once opened should be stored in the refrigerator 3. Timolol eye drops once opened has an expiration date of 28-days. <p>On 10/1/24 at 1:30PM, the surveyor discussed the above concerns to the U.S. FOIA (b) (6) [REDACTED] and U.S. FOIA (b) (6) [REDACTED]</p>	F 761			

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F 761	Continued From page 18 There was no additional information provided. A review of the facility's policy titled "Storage of Medications" dated 1/31/24 and provided by the DON included the following: "4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." "5. Medications requiring refrigeration must be stored in a refrigerator in the drug room at the nurses' station or other secured location." Medications must be stored separately from food and must be labeled accordingly."	F 761			
F 806 SS=F	NJAC: 8:39-29.4 (a) (h) (d) Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure that resident's dietary preferences were consistently implemented and correct diet	F 806	1. The dietary meal tickets and preferences, for Residents #8, #19, and #51, were immediately corrected. 2. All residents are at risk to be affected by this deficient practice.	11/8/24	

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F 806	<p>Continued From page 19</p> <p>consistency was followed for 3 of 5 residents (Resident #8, #19, and #51) reviewed for dietary preferences.</p> <p>This deficient practice was evidenced as follows:</p> <p>1. On 9/26/24 at 08:35 AM, the surveyor observed Resident #8 in their room, awake in bed. During the interview, Resident #8 stated their meal trays are usually missing items and/or have incorrect items. Resident #8's breakfast tray arrived during the interview. Resident #8's breakfast ticket stated the resident was on a NJ Ex Order 26.4 diet with NJ Ex Order 26.4(b)(1)" NJ Ex Order 26.4(b)(1)</p> <p>NJ Ex Order 26.4) The surveyor observed Resident #8's tray were missing a 4 ounce (oz) pureed fruit cup and a 4 oz apple/cran-orange juice as indicated in their meal ticket. The surveyor further observed a piece of coffee cake in NJ Ex Order 26.4(b)(1). As indicated in the meal ticket, the coffee cake should be served in NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1)</p> <p>NJ Ex Order 26.4(b)(1)). The certified nursing assistant #1 (CNA #1), called the kitchen to request for the missing items on the resident's tray and clarified what was the NJ Ex Order 26.4(b)(1) of the coffee cake the resident should receive.</p> <p>A review of the Admission Record (an admission summary) (AR) reflected that the resident was admitted with diagnoses that included but were not limited to: NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) NJ Ex Order 26.4(b)(1) and NJ Ex Order 26.4(b)(1).</p> <p>A review of the Quarterly Minimum Data Set</p>	F 806	<p>3. U.S. FOIA (b) (6)) was in serviced by the Administrator on 10/21/24 regarding Meal ticket accuracy, tray accuracy and meal preferences.</p> <p>4. Administrator or designee will audit 3 trays a week, for 4 weeks, and 2 trays a week for the next 2 months. Results will be brought to the quarterly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meeting.</p>		

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F 806	<p>Continued From page 20</p> <p>(MDS), a tool used to facilitate the management of care, dated [REDACTED] NJ Ex Order 26.4(b)(1), reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [REDACTED] out of 15, which reflected that Resident #8 was [REDACTED] NJ Ex Order 26.4(b)(1).</p> <p>A review of the [REDACTED] NJ Ex Order 26.4(b)(1) Physician's Orders (PO) included a PO dated [REDACTED] NJ Ex Order 26.4(b)(1) for a [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1).</p> <p>A review of Resident #8's [REDACTED] NJ Ex Order 26.4(b)(1) progress note form dated [REDACTED] NJ Ex Order 26.4(b)(1) at 8:30 AM, reflected that the [REDACTED] U.S. FOIA (b) (6) documented "Food preferences: no new preferences at this time." Specific food preferences were not indicated within the assessment.</p> <p>2. On 9/26/24 at 8:55 AM, the surveyor observed Resident #19 who was in their bed and awake. The resident stated their meal trays are frequently missing some items that they had specifically requested. The surveyor observed, Resident #19's breakfast tray, the breakfast ticket stated the resident is on a [REDACTED] NJ Ex Order 26.4(b)(1) diet, [REDACTED] NJ Ex Order 26.4(b)(1), and [REDACTED] NJ Ex Order 26.4(b)(1). The surveyor observed Resident #19's tray was missing a 4 oz cranberry juice. Resident #19 stated they were supposed to receive cranberry juice with each meal. On 9/26/24 at 12:55 PM, the surveyor observed Resident #19's lunch meal tray that didn't have the 4oz cranberry juice was missing.</p> <p>A review of the AR reflected Resident #19 was admitted to the facility with diagnoses that included but were not limited to; [REDACTED] NJ Ex Order 26.4(b)(1), [REDACTED] NJ Ex Order 26.4(b)(1) and [REDACTED] NJ Ex Order 26.4(b)(1).</p>	F 806			

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

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315492	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/02/2024
NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 806	<p>Continued From page 21</p> <p>A review of the Quarterly MDS, a tool used to facilitate the management of care, dated [REDACTED], indicated that the resident had a BIMS score of [REDACTED] out of 15, which reflected that the resident was [REDACTED].</p> <p>A review of the [REDACTED] PO included a PO dated [REDACTED] for a [REDACTED], [REDACTED], [REDACTED], [REDACTED].</p> <p>A review of Resident #19's [REDACTED] progress note dated 7/5/24 at 8:30 AM, reflected that the [REDACTED] (U.S. FOIA (b) (6)) documented "The resident would also like ginger ale and cranberry juice each meal, reported to [REDACTED] (U.S. FOIA (b) (6))."</p> <p>A review of Resident #19's [REDACTED] care plan dated [REDACTED], under interventions and tasks stated, "Provide me with my food/beverage preferences."</p> <p>3. On 9/26/24 at 9:03 AM, the surveyor observed Resident #51 awake in their bed. Resident #51 stated, they had to call the kitchen almost every meal for the missing items in their meal tray. The surveyor observed the breakfast served to the resident on the same day. The meal ticket stated the resident was on a [REDACTED] (NJ Ex Order 26.4(b)(1)), [REDACTED] (NJ Ex Order 26.4(b)(1)) diet, [REDACTED] (NJ Ex Order 26.4(b)(1)), [REDACTED] (NJ Ex Order 26.4(b)(1)). The surveyor observed Resident #51's tray was missing a 4-ounce (oz) prune juice.</p> <p>A review of the AR indicated that Resident #51 was admitted to the facility with diagnoses that included but were not limited to; [REDACTED] (NJ Ex Order 26.4(b)(1)), [REDACTED] (NJ Ex Order 26.4(b)(1)) and [REDACTED] (NJ Ex Order 26.4(b)(1)).</p>	F 806			

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NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 199 POWERVILLE ROAD BOONTON, NJ 07005		
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F 806	<p>Continued From page 22</p> <p>A review of the Annual MDS, a tool used to facilitate the management of care, dated [REDACTED] revealed that the resident's BIMS was not completed due to the resident's interview was not able to be conducted at that time.</p> <p>A review of the [REDACTED] PO included a PO dated [REDACTED] for a [REDACTED], [REDACTED].</p> <p>A review of Resident #51's [REDACTED] Progress note dated [REDACTED], reflected that the [REDACTED] documented "noted order for prune juice in the morning for [REDACTED]"</p> <p>A review of Resident #51's [REDACTED] care plan dated [REDACTED] under interventions and tasks stated, "Provide and serve diet as ordered."</p> <p>On 9/27/24 at 9:46 AM, the surveyor interviewed the [REDACTED] who stated, they were not aware of the missing items on the resident's trays and weekly tray audits were completed by the [REDACTED] together with the [REDACTED]. The [REDACTED] also stated Resident #8 was served the correct [REDACTED] coffee cake, but unable to provide information as to why the tray ticket stated [REDACTED].</p> <p>On 9/30/24 at 12:41 PM, the [REDACTED] provided the surveyor with a facility policy titled, Tray identification/Accuracy policy with a revision date of 4/24/24. Under the policy interpretation and implementation, it states, "1. To assist in setting up and serving the correct food trays/diets to residents, the food Service Department shall use appropriate identification (e.g., color coded or</p>	F 806			

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NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 199 POWERVILLE ROAD BOONTON, NJ 07005		
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F 806	Continued From page 23 computer-generated diet cards) to identify the various diets. 2. The Food Services manager or supervisor shall check trays for correct diets before the food carts are transported to their designated areas. 3. Nursing staff shall check each food tray for the correct diet before serving the residents. 4. If there is an error, the Nurse Supervisor shall notify the Dietary Department immediately by phone so that the appropriate food tray can be served." On 9/30/24 at 1:16 PM, the surveyor interviewed the [U.S. FOIA (b)] who stated the kitchen staff placed pitchers of juice on the tray carts that goes to the nursing units to be served. The [U.S. FOIA (b)] further stated that the nursing staff on the units were supposed to pour the juices into the cups and pass them out to the residents. On 9/30/24 at 1:33 PM, the survey team met with the [U.S. FOIA (b)] and [U.S. FOIA (b) (6)] to discuss the above concerns. The [U.S. FOIA (b)] stated the missing tray items were not acceptable. There were no further information provided.	F 806			
F 812 SS=F	NJAC - 17.4(a)1, (e) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812			11/8/24

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NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 199 POWERVILLE ROAD BOONTON, NJ 07005		
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F 812	<p>Continued From page 24</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and review of facility policies, it was determined that the facility failed to maintain proper kitchen sanitation practices in a manner that would prevent food borne illnesses.</p> <p>This deficient practice was observed and evidenced by the following:</p> <p>On 9/25/24 at 09:41 AM, the surveyor in the presence of the U.S. FOIA (b) (6)) observed the following during the kitchen tour:</p> <ol style="list-style-type: none"> 1. The juice dispensing machine was observed with 3 of 6 juice plastic tubes that lead from the juice concentrate to the juice dispenser, with a sticky substance covering the tubes. The U.S. FOIA stated the tubing should always be clean and free of any debris. 2. In walk-in refrigerator #1, the surveyor observed the fans, fan grates and panels with a dark colored dust like debris. 3. In the walk-in freezer, the surveyor observed large ice and frost build up on the fans, walls, and ceiling. The U.S. FOIA could provide an information 	F 812	<ol style="list-style-type: none"> 1. The juice machine tubing was immediately cleaned. The walk-in refrigerator fan grates and panels were immediately cleaned. The ice build-up in the walk-in freezer was immediately removed. 2. All residents are at risk of being affected by this deficient practice. 3. The Administrator in-serviced the Food Service Director on 10/21/24 regarding proper kitchen cleanliness. 4. Administrator or designee will audit these items twice a month for 3 months. Results will be brought to the quarterly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meeting. 		

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F 812	<p>Continued From page 25 why the frost build up occurred.</p> <p>On 9/26/24 the U.S. FOIA (b) (6) provided the surveyor with two undated facility policies, titled, "Dietary Cleaning" and "Food Storage" The dietary cleaning policy stated under the procedure section, "I. The dietary manager will develop a cleaning schedule that includes the frequency of which equipment, and areas will be cleaned. A. The cleaning schedule will be posted weekly. B. The cleaning schedule includes tasks assigned to specific positions within the dietary department. C. Dietary staff will initial next to the assigned task once it is completed. The dietary manager monitors the cleaning schedule to ensure compliance." The U.S. FOIA (b) (6) also provided a blank copy of the weekly deep cleaning list which included the tasks of cleaning the freezers and refrigeration. The U.S. FOIA (b) (6) and U.S. FOIA (b) (6) unable to provide the most recent copy of the weekly deep cleaning list.</p> <p>On 9/30/24 at 1:33 PM, the survey team met with the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) to discuss the above concerns. There were no further information provided.</p> <p>NJAC 8:39-17.2(g)</p>	F 812			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2024
NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION (STREET ADDRESS, CITY, STATE, ZIP CODE 199 POWERVILLE ROAD BOONTON, NJ 07005		
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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 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: Complaint #'s: NJ175578, NJ170736, NJ166580 Based on interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18	S 560	1. The facility cannot retroactively correct this deficient practice. 2. All residents are at risk of being affected by this deficient practice. 3. Staffing coordinator was in-serviced on 10/21/24 by the administrator regarding state staffing ratio requirements and calculations. Facility hired full-time recruiter to ensure all nursing positions and requirements are filled. Additional staffing agency brought on. Weekend bonuses were increased. Job board posting sponsorships increased. 4. Administrator or designee will audit daily staffing daily for 4 weeks, weekly for 8 weeks, and results will be brought to the	11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/27/24

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/02/2024
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S 560	<p>Continued From page 1</p> <p>Minimum staffing requirements for nursing homes effective 2/1/21.</p> <p>1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios:</p> <p>(1) one certified nurse aide to every eight residents for the day shift;</p> <p>(2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and</p> <p>(3) 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 certified nurse aide and perform certified nurse aide duties.</p> <p>b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census.</p> <p>c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place.</p> <p>(2) If the application of the ratios listed in subsection a. of this section results in other than</p>	S 560	<p>quarterly QUALITY ASSURANCE PERFORMANCE IMPROVEMENT meeting.</p>	

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/02/2024
NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION (STREET ADDRESS, CITY, STATE, ZIP CODE 199 POWERVILLE ROAD BOONTON, NJ 07005		
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S 560	<p>Continued From page 2</p> <p>a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.</p> <p>(3) All computations shall be based on the midnight census for the day in which the shift begins.</p> <p>d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...</p> <p>1. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period of complaint staffing beginning 12/25/2022 and ending 12/31/2022 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 1 of 7 day shifts as follows:</p> <p>- 12/26/22 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs.</p> <p>2. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the one-week period of complaint staffing beginning 1/21/2024 and ending 1/27/2024 revealed the facility was not in compliance with the State of</p>	S 560			

New Jersey Department of Health

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S 560	<p>Continued From page 3</p> <p>New Jersey CNA minimum staffing requirements for residents on 6 of 7 day shifts as follows:</p> <ul style="list-style-type: none"> - 01/21/24 had 10 CNAs for 94 residents on the day shift, required at least 12 CNAs. - 01/22/24 had 9 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 01/23/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 01/24/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 01/25/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 01/26/24 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. <p>3. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week period of complaint staffing beginning 7/14/2024 and ending 7/27/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 7 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> - 07/14/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 07/19/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 07/20/24 had 11 CNAs for 94 residents on the day shift, required at least 12 CNAs. - 07/21/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 07/23/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 07/26/24 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 07/27/24 had 11 CNAs for 93 residents on the 	S 560			

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 061415	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 10/02/2024
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S 560	<p>Continued From page 4</p> <p>day shift, required at least 12 CNAs.</p> <p>4. A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two-week staffing prior to survey beginning 9/8/2024 and ending 9/21/2024 revealed the facility was not in compliance with the State of New Jersey CNA minimum staffing requirements for residents on 2 of 14 day shifts as follows:</p> <ul style="list-style-type: none"> - 09/08/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 09/19/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. <p>On 10/2/2024 at 1:00 PM, the surveyor met with the Licensed Nursing Home Administrator and the Director of Nursing regarding the above concern. There was no additional information provided by the facility.</p>	S 560			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315492	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/20/2024
NAME OF FACILITY FALLSVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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 F0641	Correction	ID Prefix F0656	Correction	ID Prefix F0695	Correction
Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(1)(3)	Completed	Reg. # 483.25(i)	Completed
LSC	11/08/2024	LSC	11/08/2024	LSC	11/08/2024
ID Prefix F0755	Correction	ID Prefix F0761	Correction	ID Prefix F0806	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. # 483.60(d)(4)(5)	Completed
LSC	11/08/2024	LSC	11/08/2024	LSC	11/08/2024
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/08/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 10/2/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 061415	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 11/20/2024
NAME OF FACILITY FALLSVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 199 POWERVILLE ROAD BOONTON, NJ 07005	

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/08/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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 10/2/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			

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

PRINTED: 05/28/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315492	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments	E 000			
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/30/2024, 10/1/2024 and 10/2/2024. Falls View Rehabilitation and Nursing was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies.</p> <p>The building construction was stated to be 1980's with no current major renovations or noted additions. It is a two-story building Type V (000) construction and is fully sprinklered. The 2-exterior generators (1) 15 KW natural gas fuel and (1) diesel 200 KW and they do approximately 80% of the building. The facility has 9-smoke zones. The facility's fire sprinkler system works off city pressure and has a below ground water tank that is pressurized by a compressor, when activated will provide water to the system. The two (2) generators outside the facility are stated to be tied to the fire alarm control panel, cross corridor door hold open devices, exterior door releases, emergency facility lighting, and life safety components utilized for preservation of life. The facility has an ongoing K-161 and the facility will have to have an updated Fire Safety</p>	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/27/2024

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.

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K 000	Continued From page 1	K 000			
K 161	Evaluation System (FSES).	K 161			
SS=F	Building Construction Type and Height CFR(s): NFPA 101				11/8/24
	Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5				
	Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered				
	2 II (111) One story non-sprinklered Maximum 3 stories sprinklered				
	3 II (000) Not allowed non-sprinklered				
	4 III (211) Maximum 2 stories sprinklered				
	5 IV (2HH)				
	6 V (111)				
	7 III (200) Not allowed non-sprinklered				
	8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the				

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K 161	<p>Continued From page 2</p> <p>construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by:</p> <p>During a tour of the building on 10/1/2024 from 8:15 AM to 3:45 PM, the surveyor observed that the Evergreen and Magnolia sections (combined) were a 2-story wood frame construction type, exceeding the 1-story height requirement for a wood frame building. This finding was confirmed by the facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) in an interview during a tour of the Evergreen and Magnolia sections of the building at approximately 2:00 PM.</p> <p>During the facility's Life Safety Code survey exit conference on 10/2/2024 at 02:30 PM, the surveyor informed the facility's U.S. FOIA (b) (6) and U.S. FOIA (b) (6) that Evergreen and Magnolia sections of the building did not comply with the construction requirements of NFPA 101:2012.</p> <p>The facility has a time-limited waiver to construct corridors in the basement which should result in a passing FSES. The time-limited waiver expires on 8/22/2025.</p> <p>NJAC 8:39-31.1(c) NFPA 101:2012 - Table 19.1.6.1</p>	K 161	<p>1. The facility failed the FSES and failed zone 14 and zone 15. The facility requested a TLW to do construction via a passing FSES. Construction will include alterations to provide compliant corridor and eliminate the present non-compliant open-to-corridor condition.</p> <p>Construction will follow this timeline:</p> <p>Architectural Survey/Laser scan: 12/1/2023 1/15/2024</p> <p>Architectural Design: 1/15/2024 4/14/2024</p> <p>DOH Approval 4/14/2024 7/13/2024</p> <p>DCA Approval 7/13/2024 11/10/2024</p> <p>Local Building Approval 11/10/2024 12/25/2024</p> <p>Construction 12/25/2024 4/24/2025</p> <p>Local building Inspections 4/24/2025 5/24/2025</p> <p>DCA Approval 5/24/2025 6/23/2025</p> <p>DOH Final Approval 6/23/2025 8/22/2025</p> <p>2. All residents are at risk of being</p>		

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NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 161	Continued From page 3	K 161	affected by this deficient practice.		
K 351 SS=F	<p>Sprinkler System - Installation CFR(s): NFPA 101</p> <p>Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/1/2024 in the presence of the U.S. FOIA (b) (6) (redacted) and U.S. FOIA (b) (6) (redacted), it was determined that the facility failed to</p>	K 351	<p>3. Systemic Changes: The facility will keep residents , staff, and visitors free from harm <input type="checkbox"/> Construction is out of resident and visitor areas.</p> <p>4. Administrator will report project progress at quarterly QAPI meeting until completion.</p> <p>1. The process of installing the automatic sprinkler protection was continued.</p> <p>2. All residents are at risk of being</p>	11/8/24	

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K 351	<p>Continued From page 4</p> <p>provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101: 2012, Sections 9.7 and 19.3.5.1.</p> <p>This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>1. At 12:10 PM, the surveyor, [U.S. FOIA (b)] and [U.S. FOIA (b)] observed the exterior overhang on second floor, outside the conference room deck that a 5-foot by approximately 80-foot long overhang was covered with a white plastic vinyl like combustible material. The overhang was attached to a Type-V (000) building construction and was not provided with any fire sprinkler coverage.</p> <p>2. At 12:25 PM, the surveyor, [U.S. FOIA (b)] and [U.S. FOIA (b)] observed the exterior overhang on second floor, outside the rear of the building that approximately an 5-foot by 80-foot long overhang was covered with a white plastic vinyl like combustible material. The overhang was attached to a Type-V (000) building construction and was not provided with any fire sprinkler coverage.</p> <p>The [U.S. FOIA (b)] and [U.S. FOIA (b)] both confirmed the findings during the exterior overhang observations, and acknowledge this was a repeated deficient practice.</p> <p>The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at Life Safety Code Survey exit conference on 10/2/2024 at 2:30 PM.</p> <p>NJAC 8:39-31.1(c), 31.2(e) NFPA 13</p>	K 351	<p>affected by this deficient practice.</p> <p>3. Administrator in-serviced the [U.S. FOIA (b)] on the requirement for proper automatic sprinkler protection.</p> <p>4. Regional MD will oversee the progress and completion of the sprinkler system and report to Administrator upon completion. The Administrator will report the progress and updates at the quarterly Quality Assurance Performance Improvement meeting.</p>		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353			11/8/24

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K 353	<p>Continued From page 5</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 10/1/2024 in the presence of the U.S. FOIA (b) (6) [REDACTED] and U.S. FOIA (b) (6) [REDACTED], it was determined that the facility failed to maintain all parts of the automatic fire sprinkler heads free from corrosion in accordance with NFPA 25: 2011 Edition, Section 5.2.1.1.1 NFPA 101: 2012 Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13: 2010 Edition, Section 6.2.7.1.</p> <p>This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 12:15 PM in the Facility's Kitchen, revealed 2 of 6 sprinkler heads were green with a coating of oxidation.</p>	K 353	<p>1. The sprinkler heads were immediately cleaned.</p> <p>2. All residents are at risk of being affected by this deficient practice.</p> <p>3. Administrator in-serviced the U.S. FOIA (b) (6) [REDACTED] on 10/21/24 regarding Sprinkler Head Maintenance.</p> <p>4. Regional MD or designee will audit 5 sprinkler heads a month for 3 months, results will be brought to quarterly Quality Assurance Performance Improvement meeting.</p>		

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NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 199 POWERVILLE ROAD BOONTON, NJ 07005		
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K 353	Continued From page 6 In an interview at that time, the [U.S. FOIA] and [U.S. FOIA] confirmed the observation. The facility's [U.S. FOIA (b) (6)] was informed of the deficient practice at the Life Safety Code survey exit on 10/2/2024 at 2:20 PM. N.J.A.C 8:39-31.2(e) NFPA 25	K 353			
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other	K 363			11/8/24

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K 363	<p>Continued From page 7</p> <p>materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485</p> <p>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview on 10/1/2024, in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101: 2012 Edition, Section 19.3.6, 19.3.6.3, 19.6.3.1 and 19.6.5.</p> <p>This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>During the tour from 9:15 AM to 3:30 PM, the surveyor, U.S. FOIA (b) (6) and U.S. FOIA (b) (6) observed the following:</p> <ol style="list-style-type: none"> 1. Resident room #114 door was stuck at the bottom when tested by the U.S. FOIA (b) (6) 2. One of the double doors between room #223 and the elevator had a gap on top when tested by the U.S. FOIA (b) (6) <p>In an interview at the time, the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) confirmed the observation.</p>	K 363	<ol style="list-style-type: none"> 1. The issues were immediately corrected. 2. All residents are at risk of being affected by this deficient practice. 3. Administrator in-serviced the U.S. FOIA (b) (6) on 10/21/24 regarding the requirements for corridor doors to resist the passage of smoke. 4. Administrator will audit 3 doors a month for 3 months, results will be brought to the quarterly Quality Assurance Performance Improvement meeting. 		

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K 363	Continued From page 8 The facility's U.S. FOIA (b) (6) was notified of the deficient practice at Life Safety Code Survey exit conference on 10/2/2024 at 2:30 PM.	K 363			
K 511 SS=F	NJAC 8:39-31.1(c), 31.2(e). Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/1/24 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) it was determined that the facility failed to ensure that 1 of 2 gas boilers was equipped with a remote manual stop station in accordance with NFPA 101:2012 Edition, Section 9.5, 19.5.1. NFPA 54 National Fuel and Gas Code, and NFPA 70 National Electric Code. This deficient practice has the potential to affect all residents of the facility and was evidenced by the following: An observation at 1:51 PM in the boiler room, revealed that 1 of 2 boilers was not equipped with	K 511	1. The issue was corrected immediately. 2. All residents are at risk of being affected by this deficient practice. 3. Administrator in-serviced the U.S. FOIA (b) (6) on 10/21/24 regarding the Boiler Remote Manual Emergency Stop Switch. 4. Administrator or designee will audit the boiler stop switch once a month for 3 months, results will be brought to the quarterly Quality Assurance Performance Improvement meeting.		11/8/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315492	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 511	Continued From page 9 a Remote Manual Emergency Stop Switch remote from the unit. There was an emergency stop located on the boiler what was not remote from the unit to shut down in a catastrophic failure. In an interview at the time of observation, the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] confirmed the boiler was not equipped with a manual stop station that was remote from the unit. The facility's [U.S. FOIA (b) (6)] was informed of the deficient practice during the Life Safety Code exit conference on 10/2/2024 at 2:30 PM. N.J.A.C 8:39-31.2(e) NFPA 54, 70	K 511			
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and	K 531			11/8/24

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K 531	<p>Continued From page 10 elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review and interview on 9/30/2024 and 10/1/2024, in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to repair and maintain elevators and emergency communication telephones for 1 of 2 elevators telephones tested in accordance with ASME/ANSI A17.3 and NFPA 101:2012 Edition, Section 19.5.3, 9.3.2, and 9.4.3.</p> <p>This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Documentation review on 9/30/2024, revealed the following:</p> <p>1. An annual inspection report dated 6/12/2024 for elevator #2, indicated a) Car Gate/Door Accessories/Car Door Reopening Device - UNSATISFACTORY. b) Car Gate or Door Operator - UNSATISFACTORY.</p> <p>2. An annual inspection report dated 6/12/2024 for elevator #1, indicated Emergency Signals & Communication - UNSATISFACTORY.</p> <p>In an interview at that time, the U.S. FOIA and U.S. FOIA confirmed the findings.</p> <p>On 10/1/2024 at 1:39 PM, the U.S. FOIA conducted a test of the emergency communication telephone system in the facility passenger elevator #1. The emergency telephone did not function when the button was activated.</p>	K 531	<p>1. Elevator repair company was immediately contacted to repair the issues.</p> <p>2. All residents are at risk of being affected by this deficient practice.</p> <p>3. Administrator in-serviced the U.S. FOIA (b) (6) on 10/21/24 regarding the safety requirements for elevators.</p> <p>4. Administrator will audit 1 elevator a month for 3 months, results will be brought to the quarterly Quality Assurance Performance Improvement meeting.</p>		

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NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 199 POWERVILLE ROAD BOONTON, NJ 07005		
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K 531	Continued From page 11 In an interview at that time, the [U.S. FOIA (b) (6)] and [U.S. FOIA (b) (6)] confirmed and acknowledged the findings. The facility's [U.S. FOIA (b) (6)] was notified of the deficient practice at Life Safety Code Survey exit conference on 10/2/2024 at 2:30 PM. N.J.A.C 8:39-31.2(e) ASME/ANSI A-17.3	K 531			
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview on 09/30/2024 in the presence of the [U.S. FOIA (b) (6)] [REDACTED], it was determined that the facility failed to conduct fire drills on a weekend in accordance with NFPA 101: 2012 Edition, Section 19.7.1.4 through 19.7.1.7. This deficient practice was identified for 12 of 12 fire drills, and was evidenced by the following: At 8:55 AM, the surveyor reviewed the facility's	K 712	1. The weekend fire drills were immediately done. 2. All residents are at risk of being affected by this deficient practice. 3. Administrator in-serviced the [U.S. FOIA (b) (6)] [REDACTED] on 10/21/24 regarding fire drill requirements. 4. Administrator will audit once a month		11/8/24

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K 712	Continued From page 12 fire drill reports which revealed, no records on required weekend drills for 12 of 12 fire drills conducted. In an interview at that time, the U.S. FOI confirmed the observation. The Facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code survey exit on 10/2/2024 at 2:20 PM.	K 712	for 3 months, results will be brought to the quarterly Quality Assurance Performance Improvement meeting.		
K 921 SS=F	NJAC 8:39-31.6 (b) Electrical Equipment - Testing and Maintenance CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a	K 921			11/8/24

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K 921	<p>Continued From page 13</p> <p>period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.</p> <p>10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, documentation review and interview on 9/30/2024 and 10/1/2024 in the presence of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6), it was determined that the facility failed to provide the electrical policy for all the patient care related electrical equipment (PCREE), conduct maintenance of electrical equipment and maintain a record and log of all required tests, test results and repairs in accordance with NFPA 99: 2012 Edition, Sections 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, and 10.5.8.</p> <p>This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>Documentation review on 9/30/2024, revealed there was no policy on patient care related electrical equipment.</p> <p>In an interview at the time, the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) stated they checked all PCREE equipment but could not provide a policy and procedure for testing of the equipment or evidence of annual testing and maintenance program for PCREE.</p> <p>Observations on 10/1/2024 from 9:10 AM to 3:30 PM, revealed that all fixed and portable patient-care related equipment (PCREE) had no inspection stickers throughout the facility.</p>	K 921	<p>1. The issues were immediately corrected and a policy was immediately prepared.</p> <p>2. All residents are at risk of being affected by this deficient practice.</p> <p>3. Administrator in-serviced the U.S. FOIA (b) (6) on 10/21/2024 on the requirements regarding electrical equipment testing and maintenance.</p> <p>4. Administrator or designee will audit 3 items a week for 1 month, and 1 item per week for the next 2 months. Results will be brought to the quarterly Quality Assurance Performance Improvement meeting.</p>		

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K 921	Continued From page 14 An interview at that time, the US FOI confirmed the finding and acknowledged that no policy was provided. The facility's U.S. FOIA (b) (6) was informed of the deficient practice at the Life Safety Code exit conference on 10/2/2024 at 2:30 PM. NJAC 8:39-31.2(e) NFPA 99	K 921			
K 923 SS=E	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room,	K 923			11/8/24

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K 923	<p>Continued From page 15</p> <p>where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and interview on 10/1/2024 in the presence of the U.S. FOIA (b) (6) it was determined that the facility failed to ensure that empty portable oxygen cylinder tanks were separated from full portable oxygen cylinder tanks in accordance NFPA 101: 2012 Edition, Section 19.3.2.4, 8.7 and NFPA 99.</p> <p>This deficient practice had the potential to affect all residents and was evidenced by the following:</p> <p>An observation at 11:43 AM in the facility's oxygen storage closet, revealed 2 of 20 full portable oxygen cylinder tanks were in a storage rack with sign indicating Empty Tanks Only.</p> <p>In an interview at the time, the U.S. FOIA confirmed the observation.</p> <p>The facility's U.S. FOIA (b) (6) was informed of the deficient practice during the Life Safety Code exit conference on 10/2/2024 at 2:30 PM.</p> <p>N.J.A.C 8:39-31.2(e)</p>	K 923	<ol style="list-style-type: none"> 1. This issue was immediately corrected. 2. All residents are at risk of being affected by this deficient practice. 3. Nurses were in-serviced by maintenance director (MD) on 10/21/24 regarding proper oxygen storage. 4. Administrator or designee will audit 1 Oxygen storage area per month for 3 months, results will be brought to the quarterly Quality Assurance Performance Improvement meeting. 		

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K 923	Continued From page 16 NFPA 99	K 923			

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315492	MULTIPLE CONSTRUCTION A. Building 01 - MERRY HEART OF BOONTON B. Wing	DATE OF REVISIT 11/20/2024
NAME OF FACILITY FALLSVIEW NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0161	11/08/2024	LSC K0351	11/08/2024	LSC K0353	11/08/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0363	11/08/2024	LSC K0511	11/08/2024	LSC K0531	11/08/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0712	11/08/2024	LSC K0921	11/08/2024	LSC K0923	11/08/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE	
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE	
FOLLOWUP TO SURVEY COMPLETED ON 10/2/2024		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO			