

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 11/22/2024
NAME OF PROVIDER OR SUPPLIER FALLSVIEW NURSING AND REHABILITATION (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) COMPLETE DATE
S 000	<p>Initial Comments</p> <p>Survey Date: 11/22/2024</p> <p>Census: 84</p> <p>A project survey was conducted on 11/22/2024 at Fallsview Nursing and Rehabilitation Center for the renovation of: Rooms 131, 132, 133, 134, 135, 136, 139, 140, 141, 142, 143, 144 and 145; the Catalina Dining Room; Rehabilitation Room; and Exterior Entrance Vestibule. Fallsview Nursing and Rehabilitation Center was found to be in compliance with N.J.A.C. 8:39.</p> <p>The facility may not occupy the above areas until the New Jersey Certificate of Need and Licensing approval.</p>	S 000		

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

TITLE

(X6) DATE

Electronically Signed

11/25/24