STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315359	A. BUILDING _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	**155 40TH STREET IRVINGTON, NJ 07111**

(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 A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00160452, NJ00160767, NJ00160860, NJ00161873, NJ00162591, NJ00163313, NJ00163386, NJ00163835, AND NJ00164143 Survey Dates: 08/01/23 through 08/04/23 Survey Census: 139 Sample Size: 27 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		8/28/23

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

Electronically Signed | 08/25/2023

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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	315359	A. BUILDING _____ B. WING _____	C 08/04/2023

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F 584	Continued From page 1 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews, the facility failed to maintain a safe clean homelike environment for residents. This involved three resident rooms affecting four (Resident (R) 25, R26, R27, and R19) of 27 sampled residents who currently reside in the facility. Findings include: Review of R25's Admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of [redacted] located in the "MDS" tab of the	F 584	1.The floor in R25 room and the walls were cleaned. The fan was removed. The brown spot on the wall next to the outlet located next to the hand sink in the room was removed. The wall and floor under the sink in R26 and R27's room cleaned. The privacy curtain was replaced with a cleaned one. The wall next to the bed by the door was cleaned. The headboard was fixed. The hole in the wall next to the bed by the door was repaired.	

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F 584	Continued From page 2 electronic medical record (EMR) revealed she had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating she was [redacted]. Observation on 08/03/23 at 8:50 AM, 1:45 PM and on 08/04/23 at 10:50 AM the floor in R25's room had dirt built up along the walls. A fan was observed in the room with the cover off exposing the blades. On 08/03/23 at 8:50 AM and 1:45 PM the fan was running with the blades exposed and not protected. During each of the observations there was a brown spot on the wall next to the outlet located next to the hand sink in the room. R25 stated she had been in the facility for three weeks and the floor and the spot on the wall had been soiled ever since she arrived at the facility. She stated they do not clean the room. On 08/04/23 at 10:50 AM the Administrator was present and verified the observations. Observation on 08/01/23 at 12:06 PM, 1:50 PM, and on 08/04/23 at 10:49 AM the wall and floor under the sink in R26 and R27's room was soiled with an orange color substance. The floor under the hand sink in the room was soiled with a heavy build up along the walls. The privacy curtain located between the two beds in the room was soiled with a brown substance in an oval shape about one inch by one and a half inch. The wall next to the bed by the door was soiled with what appeared to be dried spills, the headboard had fallen off the wall on one side and there was a hole in the wall next to the bed by the door. On 08/04/23 at 10:49 AM the Administrator was present and verified the observation. Observation on 08/03/23 at 9:23 AM and on 08/04/23 at 10:55 AM R19's floor had a heavy	F 584	The floor, corners and walls in R19's room were cleaned. The wall next to the outlet located by the hand sink in the bedroom was cleaned. 2. All residents have the potential to be affected. 3. Policy and procedures for inspecting walls, fans, curtains, walls and corners were reviewed by the Administrator and found t.o be in compliance. The Maintenance Director was re-educated on the maintenance P&P and on ensuring holes in the walls are repaired when identified. The Housekeeping supervisor was re-educated on the housekeeping P & P and on ensuring cleanliness of floors, corners, walls and privacy curtains are cleaned regularly on 8/4/2023 by the Administrator. All housekeeping staff were educated on policy and procedures regarding cleanliness of resident's rooms by the Housekeeping Supervisor. 4. The Maintenance Director will conduct 3 rooms audit weekly to ensure residents rooms are without holes in the walls for 4 weeks and monthly for two months and quarterly thereafter. The Housekeeping Supervisor will conduct 3 rooms audits weekly of residents' rooms to ensure cleanliness of floors, corners, walls and privacy curtains for 4 weeks and monthly for two months and quarterly thereafter.	

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	315359	A. BUILDING _____ B. WING _____	C 08/04/2023

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F 584	Continued From page 3 buildup of dirt along the walls and in the corners and there was a brown spot resembling [redacted] on the wall next to the outlet located by the hand sink in the bedroom. On 08/04/23 at 10:55 AM the Administrator was present and verified the observation. NJAC 8:39-4.1 (a) 11	F 584	A report will be submitted to the Quality Assurance Performance Improvement Committee for review and recommendation at the next QAPI and then quarterly x2. The Administrator or designee is responsible for on-going monitoring and compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060736	A. BUILDING: _____ B. WING _____	C 08/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CE	155 40TH STREET IRVINGTON, NJ 07111

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S 000	Initial Comments Complaint #: NJ00160452, NJ00160767, NJ00160860, NJ00161873, NJ00162591, NJ00163313, NJ00163386, NJ00163835, AND NJ00164143 Survey Dates: 08/01/23 through 08/04/23 Survey Census: 139 Sample Size: 27 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: C# NJ 164143, NJ 160860 Based on review of pertinent facility documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident	S 560	ELEMENT: 1 Immediate Action: 1. The Administrator and Director of Nursing met with the Staffing Coordinator to determine current staffing vacancies in the nursing department to ensure	8/28/23

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 1 ratios as mandated by the state of New Jersey for 8 of 36 day shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 5 weeks of staffing from 01/08/2023 to 01/29/2023 and 7/16/23 to 07/29/2023, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: 1. For the 5 weeks of staffing from 01/08/2023 to 01/29/2023 and 7/16/23 to 07/29/2023, the facility was deficient in CNA staffing for residents on 8 of	S 560	accuracy of facility needs. 2. The facility has reviewed current salaries in comparison to other facilities in the immediate area to ensure salary competitiveness within the community. 5. Nursing Administration is available for interviews, hiring and training as needed to ensure all potential candidates are interviewed, evaluated and offered positions if appropriate. (Ongoing) 6. The facility continues to offer incentives including referral bonuses and other incentives. 7. The facility advertises on various platforms such as social media, posted flyers in various community establishments, colleges and schools. We have partnered with C.N.A. schools, hung banners across facility proper to enhance our recruitment efforts. We have encouraged word of mouth referrals to employees and the community. (Ongoing) 8. The facility works with a full-time recruiter whose sole responsibility is to recruit nurses and C.N.A.s. ELEMENT 2: Identification of Others: All residents have the potential to be affected by this deficient practice. No residents were affected by this deficient practice. ELEMENT 3: Systemic Changes 1. The Administrator, Director of Nursing, Human Resource Director have reviewed the state staffing ratios with the Staffing Coordinator to ensure meeting the state required ratios is the primary focus for staffing the facility. 2. The Staffing Coordinator was instructed to notify the Director of Nursing	

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	060736	A. BUILDING: _____ B. WING _____	C 08/04/2023

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S 560	Continued From page 2 36 day shifts as follows: 1.For the 3 weeks and 1 day of staffing from 01/08/2023 to 01/29/2023, the facility was deficient in CNA staffing for residents on 6 of 22 day shifts as follows: -01/11/23 had 15 CNAs for 126 residents on the day shift, required at least 16 CNAs. -01/20/23 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -01/21/23 had 16 CNAs for 140 residents on the day shift, required at least 17 CNAs. -01/22/23 had 15 CNAs for 140 residents on the day shift, required at least 17 CNAs. -01/28/23 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. -01/29/23 had 17 CNAs for 141 residents on the day shift, required at least 18 CNAs. 2.For the 2 weeks of staffing prior to survey from 07/16/2023 to 07/29/2023, the facility was deficient in CNA staffing for residents on 2 of 14 day shifts as follows: -07/20/23 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. -07/29/23 had 15 CNAs for 138 residents on the day shift, required at least 17 CNAs.	S 560	and/or the Administrator when staffing ratios are not being met so they can lend assistance in fulfilling those ratios. 3. Human Resource Director will complete exit interviews for all nursing employees who have vacated their positions in an attempt to address any issues which could be affecting retention of employees. (Ongoing) 4. Orientation will be done on an ongoing basis as needed to ensure that all potential candidates for employment will have opportunities to complete the orientation as soon after accepting a facility offer. Element 4: Quality Assurance 1. The staffing coordinator or designee will compile a tracking log that will be maintained for all communication with referrals, applicants, interviews, newly hired, orientation completion and success of recruitment efforts and will be reviewed monthly by Director of Nursing, Administrator and Human Resource Director. 2. All findings will be reviewed by the Quality Assurance Team at least quarterly, and changes made as needed to improve facility ratios. V. Responsibility: Administrator, Director of Nursing and Human Resource Director	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060736 Y1	A. Building B. Wing Y2	8/28/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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 Reg. # 8:39-5.1(a) LSC	Correction Completed 08/28/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
8/4/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315359	A. Building B. Wing	8/28/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 08/28/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
8/4/2023	