STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	1 SUMMIT AVENUE NEWTON, NJ 07860

(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 This facility is not in substantial compliance with Appendix Z-Emergency Preparedness for All Provider and Supplier Types Interpretive Guidance 483.73, Requirements for Long Term Care (LTC) Facilities.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal.	E 015		12/15/23

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

Electronically Signed | 12/15/2023

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E 015	Continued From page 1 *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based upon observations, staff interviews and review of facility documents, it was determined that the facility failed to a.) have an emergency menu readily available and b.) have all of the menu items in stock, in accordance with facility policy and emergency menu. The deficient practice was evidenced by the following: On 11/15/2023 at 10:25 AM, two surveyors conducted a kitchen tour with the Food Service Director (FSD). On 11/15/2023 at 12:11 PM, two surveyors	E 015	Specific Corrective Action 1. The emergency food Menu Policy was reviewed/ updated and made readily available. 2. All items for the emergency menu were purchased by FSD and kept in stock. 3. FSD and cooks were in service regarding the purpose of the emergency menu and keeping all emergency supply items readily available. 4. Emergency food supply designated storage location was established. 5. FSD/Designeewill do a weekly check on the emergency menu items expiration	

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E 015	Continued From page 2 observed the dry storage area in the presence of the FSD. There was no identified emergency food in a designated area (as was observed for emergency water storage). The FSD stated, "there is no emergency food in the storeroom." He further stated, "I don't have an emergency menu. Maybe the dietitian has it." On 11/15/2023 at 12:28 PM, the surveyor, in the presence of a second surveyor, interviewed the Registered Dietitian (RD) and the FSD. Both could not speak to where the emergency menu and food were kept. The RD acknowledged, "there is no emergency food in the storage." On 11/16/23 at 10:49 AM, the FSD was unable to provide emergency menu. On 11/16/23 at 10:46 AM, the surveyor interviewed the Food Service Consultant (FSC) in the presence of the survey team. She stated that the emergency food was ordered yesterday and she acknowledged the emergency food was not in stock prior to surveyor inquiry. She further acknowledged that she "didn't have a chance to look at emergency food." In addition, she stated emergency food would have included sandwiches, juices, dry milk, crackers, and cookies. She was unable to provide an emergency menu. On 11/16/23 at 11:53 AM, during a follow-up interview with the FSC, she was unable to provide an emergency menu and acknowledged that it should be readily available. On 11/17/23 at 10:03 AM, the surveyor interviewed the FSD in the presence of a second surveyor. He acknowledged that emergency food	E 015	dates Identification All residents have the potential to be affected by this deficient practice. Systemic Changes Weekly audits on emergency food items for availability will be done FSD/Designee to ensure that emergency supply is complete and in compliance with manufactures recommendations for "use by" or "expiration" dates. In Service will be done on all new hire in the dietary department regarding the emergency food supply location, check on availability and expiration dates. Monitoring RD will do a monthly QAPI x3 months and quarterly thereafter to ensure weekly audits for the emergency food supply availability and checking on the food items expiration dates were completed and quarterly thereafter. Reports will be submitted to the administrator and will be discussed during the quarterly meeting.	

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E 015	Continued From page 3 items were delivered "yesterday" after surveyor inquiry. The FSD further stated. "I ordered it, and it came yesterday," "I ordered things like cookies, crackers and soup; things that will last a while." He stated that the RD provided a list of items to order for the "first time yesterday." He stated, "two days ago the RD and I looked through the storeroom and there was no emergency food in stock." The FSD further stated, "I do not know the purpose of the emergency menu." On 11/22/23 at 11:38 AM, the surveyor interviewed the Licensed Nursing Home Administrative Consultant in the presence of the survey team. She acknowledged the facility did not have the emergency food in stock on the start date of the survey, 11/15/23, and prior to surveyor inquiry. In addition, she acknowledged that the emergency menu was not readily available and should have been. Review of the facility policy "Emergency Food Supply" dated 4/1/23, included the purpose was to "ensure the delivery of meals that meet resident-specific dietary needs when normal food service operations are interrupted due to an emergency situation or event. Emergency food supplies will be kept separate from the normal food supply." It further included dining services were to maintain a three-day inventory of staple food products that required minimal preparation. The menu should have been kept in the diet manual as well as the emergency preparedness manual. NJAC 8:39-31.6(n)	E 015		
F 000	INITIAL COMMENTS	F 000		

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F 000	Continued From page 4 Complaint #: NJ0016243 Survey Date: 11/22/23 Census: 16 Sample: 8 + 2 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		12/15/23

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F 657	Continued From page 5 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to revise a comprehensive care plan post [NJ Exec. O]for a resident who[NJ Exec. O] and sustained a [Ex Order 26. 4B1] [redacted]. This deficient practice was identified for 1 of 1 resident (Resident #7) reviewed for[NJ Exec. Order] This deficient practice was evidenced by the following: On 11/16/23 at 11:44 AM, the surveyor observed the resident in his/her room seated in a chair combing his/her hair. The resident was able to tell the surveyor that he/she had [NJ Exec. Orde] sometime in September in the bathroom and[NJ Exec. Order 26] his/her [Ex Order 26]. The resident stated, "*Ex Order 26. 4B1*" and showed the surveyor a yellow bracelet on his/her [Ex Order 26] which indicated "[Ex Order 26. 4B1]." The surveyor reviewed the medical record for Resident #7. A review of the Admission Record reflected that the resident was admitted to the facility with diagnoses that included but not limited to: *Ex Order 26. 4B1* [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the	F 657	Specific Corrective Action Resident #7-Care plan was reviewed and updated by IDCP team to address the actual fall and fall prevention. IDCP team were in-service to update all care plan to ensure that comprehensive care plan meets the resident's current physical,psychosocial and functional needs Identification All resident have the potential to be affected by this deficient practice. System Changes Monthly audit will be done by the DON/Designee for all care plans due for review to ensure that resident's care plan is appropriately updated and reflective of current resident's condition and meet the resident's needs. Monitoring A monthly QAPI on care plan will be done by Director of Nursing -DON/Designee	

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F 657	Continued From page 6 management of care, dated Ex Order 26. 4B1 revealed that the resident had a Brief Interview for Mental Status (BIMS) score of Ex Ord out of 15 which indicated the resident had Ex Order 26. 4B1. The MDS indicated the resident was frequently Ex Order 26. 4B1. Review of section E for Health conditions in the MDS indicated the resident had one NJ Exec. O with NJ Exec. Order 2 since admission/entry or reentry or prior assessment. A review of the electronic Progress Notes (PN) dated Ex Order 26. 4B1, revealed that "at 1220 am CNA [certified nursing aide] came and said PT [patient] was on the floor had NJ Exec. Order 26 using the rest room. PT was on [his/her] Ex Order 26 and exclaimed [he/she] had Ex Order 26. 4B1 NJ Exec. Or and a visible Ex Order 26. 4B1 on the Ex Order 26. 4B1. Vital were checked ROM [range of motion] and PROM [passive range of motion] PT had Ex Order 26. 4B1 last shift and was Ex Order 26. 4B1. Dr. [name redacted] was notified along with [his/her] family member. PT was taken to [name redacted] for evaluation." Further review of the electronic PN dated Ex Order 26. 4B1, revealed that the resident returned to the facility with 'Ex Order 26. 4B1 in place" and "per hospital note has a Ex Order 26. 4B1 of Ex Order 26. 4B1. Review of the NJ Exec. Order 26:4 assessment in the electronic medical record revealed the following assessments: - NJ Exec. Order 26:4.b assessment dated Ex Order 26. 4B1 revealed a NJ Exec. Order 26:4 score of Ex O which indicated NJ Exec. Order 26:4.b. - NJ Exec. Order 26:4.b assessment dated Ex Order 26. 4B1 revealed a NJ Exec. Order 26:4 score of Ex O which indicated NJ Exec. Order 26:4.b.	F 657	monthly x3 months and quarterly thereafter to ensure that all care plan due are appropriately updated and reflective of current resident's needs and condition new physician orders were updated and reflected in the care plan when appropriate. Reports will be submitted to the administrator and will be discussed during the quarterly meeting.	

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F 657	Continued From page 7	F 657		

- [redacted] assessment dated [redacted] revealed a [redacted] score of [redacted] which indicated [redacted].

- [redacted] assessment dated [redacted] revealed a fall risk score of [redacted] which indicated [redacted].

A review of the individualized interdisciplinary care plan (IDCP) revealed a IDCP initiated on [redacted] and revised [redacted], with a focus area for at [redacted] related to *Ex Order 26. 4B1* problems and side effects of [redacted] medications. [Resident #7] has [redacted] *Ex Order 26. 4B1* and on [redacted] fell in BR [bathroom] and sustained closed [redacted] of *Ex Order 26. 4B1*. The goal of the IDCP was for the resident to be free [redacted] through the next review date.

A review of the [redacted] IDCP interventions revealed interventions dated [redacted], to monitor for [redacted] and medicate PRN [as needed], follow up with *Ex Order 26. 4B1*, and [redacted] to [redacted] as ordered. There were no updated or revised IDCP interventions to address and prevent the resident from [redacted].

On 11/17/23 at 12:20 PM, the surveyor interviewed the Director of Nursing (DON) and the Regional Administrator Consultant, a Registered Nurse (RN), who stated that the DON was responsible for developing, implementing, and updating care plans. The Regional Administrator Consultant stated that the care plan should have been updated with interventions to address and prevent the resident from [redacted] again.

At that same time, the DON stated that the care plan should have been updated either that same

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F 657	Continued From page 8 day or the next day. The Regional Administrator Consultant and the DON could not speak to why Resident #7's IDCP was not updated/revised with interventions to address and prevent further [redacted]. A review of the facility Fall policy provided by the DON included the "care plan is updated." A review of the facility Care Plans Comprehensive Person-Centered policy, provided by the DON, included that care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Care plan interventions address the underlying sources of the problem area(s), not just addressing only symptoms or triggers. The assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. The Interdisciplinary team or respective discipline must review and update the care when there is a significant change in the residents condition, when a desired outcome is not met, when a resident has been readmitted to the facility from a hospital stay and at least quarterly, in conjunction with the required quarterly MDS assessment.	F 657		
F 695 SS=D	NJAC 8:39-11.2(e)(1)(2)(h)(i), 27.1(a)(b) Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 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	F 695		12/15/23

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F 695	Continued From page 9 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: Based on observation, interview and record review, it was determined that the facility failed to clarify a Physician's Order (PO) for Ex Order 26. 4B1 administration in accordance with professional standards of practice for 1 of 1 resident reviewed for Ex Order 26. 4B1 (Resident #70). The deficient practice was evidenced by the following: On 11/15/23 at 11:41 AM, the surveyor observed Resident #70 in the facility activity room. Resident #70 was seated in a wheelchair and was participating in activities. The resident was receiving Ex Order 26. 4B1 . The Ex Order 26. 4B1 was set at Ex Order 26. 4B1 . On 11/16/23 at 11:10 AM, the surveyor observed Resident #70 in bed receiving Ex Order 26. 4B1 . The Ex Order 26. 4B1 was set at NJ Exec. Order 26:4.b.1 . The surveyor reviewed the medical record of Resident #70. Review of the Admission Record (an admission summary) revealed that the resident was admitted to the facility in November of 2023 with diagnoses which included but was not limited to; Ex Order 26. 4B1	F 695	Specific Corrective Action Resident #20- MD order was obtained for change of Ex Order 26. 4B1 at Ex Order 26. 4B1 via Ex Order 26. 4B1 continuously to Ex Order 26. 4B1 at Ex Order 26. 4B1 via Ex Order 26. 4B1 continuously. The Ex Order 26. 4B1 is documented in the Treatment Administration record (TAR) every shift All licensed staff were in- Service, when getting an Ex Order 26. 4B1 order they must add an order to check the Ex Order 26. 4B1 rate and transcribed in the TAR. Oxygen Administration Policy was updated that includes the flow rate to be check and sign in the TAR every shift. Identification All residents have the potential to be affected by this deficient practice. Systemic changes DON/Designee will do monthly audit to ensure that the Physician's order for Ex Order 26. 4B1 order of the Ex Order 26. 4B1 flow rate is the same as the	

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F 695	Continued From page 10 Ex Order 26. 4B1 [redacted] Review of the Admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1, indicated that Resident #70 had a Ex Order 26. 4B1 score of [redacted] out of 15, which indicated the resident's cognition was Ex Order 26. 4B1. Review of the November 2023 Order Summary Report (OSR) revealed a physician's order dated Ex Order 26. 4B1 for Ex Order 26. 4B1 at Ex Order 26. 4B1 via Ex Order 26. 4B1. Review of the electronic progress notes revealed a nurses note dated Ex Order 26. 4B1 at 22:03 (10:03 PM) which indicated, "Patient on Ex Order 26. 4B1 at Ex Order 26. 4B1, no NJ Exec. Order 26:4.b.1 noted. No complaints of NJ Exec. Order 26:4.b.1. Requiring NJ Exec assistance with Ex Order 26. 4B. Call bell within reach." Further review of the electronic progress notes revealed a Health Status (nursing note) dated on Ex Order 26. 4B1 at 22:28 (10:28 PM) indicated, "Resident is resting in [resident's] room watching TV when nurse came to check on [resident]. [Resident #70] verbal with needs. NJ Exec. Order 26:4.b.1 at times but NJ Exec. Order 2 [redacted] No Ex Order 26. noted however, [Resident] coughs once in a while with no little phlegm. [Resident's] on Ex Ord of Ex Order 26. 4B1 [redacted]. All medications are given with no issues. Ex Order 26. 4B1 given as ordered." On 11/16/23 at 11:15 AM, the surveyor, in the presence of a Licensed Practical Nurse (LPN),	F 695	setting of the Ex Order 26. 4B1 delivered to the resident via Ex Order 26. 4B1 and it sign in the TAR every shift. Monitoring A monthly QAPI will be done by the DON/Designee to ensure that the physician's order for in halation therapy flow rate is the same as the setting of the oxygen flow rate delivered to the resident via oxygen concentrator and and that it is being sign at the TAR x 3months and quarterly thereafter	

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F 695	Continued From page 11 observed Resident #70 in their bed receiving [redacted]. The LPN acknowledged that the resident's [redacted] was set at [redacted]. The LPN stated that the resident was receiving [redacted] at [redacted]. On 11/16/23 at 11:20 AM, in the presence of the surveyor, the LPN reviewed Resident #70's electronic OSR and she acknowledged that the resident had an order for [redacted] at [redacted]. The LPN stated that the order in the electronic OSR should have been written for [redacted] and that she would get a new order from the physician. She further stated that they were no orders to check the [redacted] settings in the electronic medication administration record. On 11/21/2023 at 12:33 PM, the surveyor, in the presence of the survey team, presented the above concerns to the Regional Licensed Nursing Home Administrator, the Director of Nursing, and the facility Infection Preventionist. No further information was provided by the facility. Review of the facility's policy "Oxygen Administration" dated 10/2023 and provided by the DON, revealed Procedures: "1. Check physician's order for liter flow and method of administration."	F 695		
F 755 SS=D	NJAC 8:39-11.2(a)(e) Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755		12/15/23

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F 755	Continued From page 12 §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(g). 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 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §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: Based on observation, interview, and record review, it was determined that the facility failed to ensure that a medication was administered according to physician orders and acceptable standards of practice in accordance with the New Jersey Board of Nursing. This deficient practice	F 755	Specific Corrective Action Resident# 9- The timing for the [redacted] medication was changed. Current physician order reads" [redacted] by mouth two times a day	

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F 755	Continued From page 13 was identified in 1 (one) of 6 (six) residents (Resident #9) observed during the medication observation pass. The deficient practice was evidenced by the following: 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." 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 licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 11/20/23 at 8:19 AM, during the medication administration observation, the surveyor observed the Licensed Practical Nurse (LPN) enter Resident #9's room. The resident was seated in their wheelchair. The surveyor observed	F 755	for Ex Order 26. 4B1 before meals with an administration time of 0700 and 1600 which is the timing for one hour before meals. LPN was re-educated to review resident's physician orders and to assure that all medications were being administered at an appropriate time and following the medication cautionary measures available in the MAR(Medication Administration Record) Identification All residents have the potential to be affected by the deficient pratice. Systemin Changes Monthly Auduts will be done by DON/Designee on all new physician orders were reviewed and to assure that all medication are being administered at an approprite time. Monthly audits will be done by the DON/Designee that recommendations from epic review by the pharmacy consultant are approved by the atteding physician and implemented. All licensed will be re-educated on medications cautionary measures by DON every other month. Monitoring	

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F 755	Continued From page 14 that the resident had an empty breakfast tray on the bedside table. The LPN informed Resident #9 that she would be administering the resident's medications. On 11/20/23 at 8:45 AM, the surveyor observed the LPN preparing to administer five (5) medications to Resident #9 which included *Ex Order 26. 4B1* [redacted]. The surveyor observed the LPN administer the medications to Resident #9. The surveyor reviewed the medical record of Resident #9. 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; *Ex Order 26. 4B1* [redacted]. A review of the Admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated *Ex Order 26. 4B1*, reflected that the resident's Brief Interview for Mental Status was [redacted] out of 15, which indicated that the resident was *Ex Order 26. 4B1*. A review of the November 2023 order summary report (OSR) revealed a physician order (PO) dated *Ex Order 26. 4B1* for *Ex Order 26. 4B1*,	F 755	Monthly QAIP will be done by DON/Designee x3 months and quarterly thereafter to make sure resident's physician's orders were reviewed and assure that all medications were being administered at appropriate time. Report will be submitted to Administration and discussed during the quarterly meeting.	

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F 755	Continued From page 15 give 1 tablet by mouth two times a day for [redacted] before meals. A review of the November 2023 electronic Medication Administration Record (eMAR) revealed an order dated [redacted], for [redacted], give 1 tablet by mouth two times a day for [redacted] before meals with an administration time of 0900 and 2100 (9AM and 9PM). A review of the Manufacturer's Specifications revealed the following: [redacted] should be administered one hour before or two hours after a meal. On 11/20/23 at 11:35 AM, the LPN in the presence of the surveyor reviewed Resident #9's electronic OSR and acknowledge that [redacted] tablet should have been administered on an empty stomach. The LPN further stated that Resident #9 was re-admitted to the facility on [redacted], and it was the responsibility of the admitting nurse to review the resident's physician orders and to assure that all medications were being administered at an appropriate time. On 11/21/23 at 1:30 PM, the surveyor presented the above observations and findings to the Regional Licensed Nursing Home Administrator, the Director of Nursing, and the facility Infection Preventionist. There was no additional information provided. A review of the facility's policy for "Medication Dispensing System" that was dated 2/28/23 and was provided by the DON included the following:	F 755		

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F 755	Continued From page 16 " J. Medication Administration: 3. Medications are administered in a timely fashion as specified by policy."	F 755		
F 801 SS=F	NJAC 8:39-11.2 (b), 29.2 (d) Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not	F 801		12/15/23

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provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services.
(i) The director of food and nutrition services must at a minimum meet one of the following qualifications-
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or
(E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food

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F 801	Continued From page 18 purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observations, interview, review of the facility assessment tool and facility job descriptions, it was determined that the facility failed to employ either a full time Registered Dietitian (RD) or a Dietary Manager (DM) that meets the qualifications to function as a director of food and nutrition services. This deficient practice was evidenced as follow: Refer to F812 F and E0015 F. On 11/15/2023 at 10:25 AM, the surveyor interviewed the Food Service Director (FSD) in the presence of a second surveyor. He stated that he had a Servsafe certification and started the position on 11/6/23. On 11/16/23 at 10:46 AM, the surveyor interviewed the FSD Consultant (FSDC) in the presence of the survey team. She stated that her credentials were Certified Dietary Manager (CDM), Certified Food Protection Professional (CFPP), and Servsafe certified . In addition, she stated that she was responsible to train the FSD. She acknowledged that today was the first day she was at the facility with the FSD. On 11/17/23 at 10:37 AM, the surveyor	F 801	Specific Corrective action 1. Registered Dietitian's job description was updated which included the oversight, training, and supervision of designated FSD. FSD will report directly to the Registered Dietitian. 2. Facility had designated a FSD who holds a CDM . 3. FSD will be trained by Registered Dietitian that includes, safely and effectively carry out the meal preparation and other food and nutrition service. Identification All resident have the potential to be affected by this deficient practice. Systemic Changes Updated the qualification and job description for the Food Service Director based on state and federal regulations.	

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F 801	Continued From page 19 interviewed the Registered Dietitian (RD) in the presence of a second surveyor. She stated that she conducted kitchen audits "occasionally" and "at least quarterly." In addition, the RD stated, she had not audited the FSD since he started. On 11/20/23 at 11:05 AM, the surveyor interviewed the FSDC, in the presence of a second surveyor, related to the interview process for the FSD. She stated, the FSD completed an application and submitted a resume for review. She stated that she and the Human Resource Generalist reviewed the documents and conducted interviews. THE FSDC described the qualifications for the FSD for the position, she spoke to the ability to cook from scratch, especially for soups. She included the ability to follow standardized recipes and must have good chopping techniques. She further stated, she showed the FSD where things were located in the kitchen and which size serving utensils were appropriate to use. She stated, "cooking skills and customer service is key." In addition, the FSDC stated, the FSD should have a "CDM qualification" or needed to be enrolled in a CDM program. She stated, "CMS [Centers for Medicare and Medicaid Services] required a CDM certification...because "it requires continuing education" to maintain the certification. The FSDC further stated, "I don't believe he (the FSD) had a CDM, but I think he has Servsafe." She added, Servsafe was a food safety course [food handler (basic food safety, appropriate food temperatures, refrigerator temperatures, and cooling techniques)], or food safety manager which included managing staff, staff scheduling, and "not food management." On 11/22/23 at 11:16 AM, the surveyor	F 801	HR will do a monthly audit to ensure that the Dietary department has sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service. Monitoring HR will do a monthly QAPI X3 months and quarterly thereatfer to ensure there is a sufficient and qualified staff with appropriate competencies and skills sets to carry out food and nutrition services.	

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interviewed the FSD in the presence of a second surveyor. The FSD stated, he thought he could handle the responsibilities of this job without training except "there are some little things like pureeing." He further stated that "it took a while to transition from restaurant to sensitive care residents."

On 11/21/23 at 1:00 PM, the surveyor conducted a phone interview with the Human Resource Generalist who stated that she participated in the hiring process. She stated that a FSD position required to a Servsafe certification and cooking experience which did not have to be in a Long-Term Care (LTC) environment.

On 11/21/23 at 1:05 PM and again at 1:19 PM, the surveyor interviewed the Licensed Nursing Home Administrator Consultant (LNHAC) in the presence of the Director of Nursing (DON) and the survey team. She stated, the FSD was qualified to hold the position since he had experience as a FS manager and had a Servsafe manager certification verse a Servsafe food handler certification. She acknowledged she was unaware of the course content or if it qualified as a food management course. The LNHAC stated that "Servsafe was adequate" and oversite from a RD was "not required." She stated, the Local Department of Health accepted his credentials but could not provide evidence. She further stated, the FSDC was qualified to oversee and audit the FSD. The LNHAC stated the FSDC audited temperatures of the food, refrigerators and dish machine. She stated, the FSDC audited quarterly and within one to two months after a new employee started. In addition, she stated the timeliness of meal deliveries and food quality could be audited by other staff including the RD.

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F 801	Continued From page 21 On 11/22/23 at 10:13 AM, the surveyor interviewed the LNHAC in the presence of the DON and survey team. She stated the minimum requirements that qualified the FSD to hold the position included experience in food management and stated that certification in food management was not required. On 11/22/23 at 10:21 AM, the surveyor interviewed the RD and the FSDC in presence of survey team. They stated, they "think" the FSD was qualified but could not speak to whether he could function independently without training. On 11/22/23 at 10:36 AM, the surveyor interviewed the LNHAC in presence of survey team. She provided the surveyor with a copy of the New Jersey State "Mandatory structural organization for dietary services" guidance. The LNHAC stated that she used that as a guide to ensure the FSD was qualified to hold the position. She further stated, she "never referred to the federal regulatory guidelines," and could not speak to why. On 11/22/23 at 11:38 AM, the surveyor interviewed the LNHAC in the presence of the survey team. She acknowledged the FSD did not have experience in a LTC environment or the required training for kitchen operations, menus, how to interpret the menus, therapeutic diets [medically prescribed], preparation of special diets, and how things should be stored. In addition, the LNHAC stated, he could "probably be able to function without training," "but it would take time." She stated he required training "in this type of environment."	F 801		

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F 801	Continued From page 22 Review of the "Facility Assessment Tool" dated 7/17/23, indicted "Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies, Staff Type," should include "Food and Nutrition Services; Certified Dietary Manager, support staff, registered dietitian." Review of the FSD's resume provided to the surveyor by the DON on 11/17/23 at 10:00 AM, reflected that he did not have work experience in LTC, and his education included "Servsafe Food Handler," with an expiration date of 11/22/24. In addition, the facility provided the FSD's Servsafe certification for Food Protection Manager Examination, dated 10/24/23. Review of the undated facility provided job description for "Food Service Director," did not include required qualifications. It included that the FSD "ensures that all federal, state, departmental, and other necessary government agency requirements are met in the preparation of food," and "cook foodstuffs according to menus, special dietary and nutritional restrictions, ..." Review of the undated facility provided job description for "Registered Dietitian", did not include frequently scheduled consultations to the FSD.	F 801		
F 812 SS=F	NJAC 8:39-17.1(a) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		11/23/23

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F 812	Continued From page 23 §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. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §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: Based on observation, interview, and record review, it was determined that the facility failed to a.) store foods in a sanitary manner, b.) ensure the kitchen environment and equipment was maintained in a clean and sanitary manner, and c.) handle dishware in a manner to prevent cross contamination, to limit potential bacteria growth and potential food borne illness. The deficient practice was evidenced by the following: On 11/15/2023 at 10:25 AM through 12:28 AM, the surveyor conducted a kitchen tour with the Food Service Director (FSD) in presence of a second surveyor. At 10:26 AM, the surveyor observed a dish machine temperature log which was filled out for the entire day (afternoon and dinner time). The	F 812	Specific Corrective Action -All Identified open food items with no open date, not labeled, or expired have been removed and discarded. -Food storage areas were clean and sanitized. -The kitchen envoronment and equipment were cleaned and sanitized and kept maintained in a sanitary manner. - Dishware and silverware were cleaned and sanitized to prevent cross contamination and bacterial growth. Silverware found on the floor ternish and was discarded.	

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F 812	Continued From page 24 Cook stated, "it was a mistake, usually I check the temperatures and then log them in." At 10:27 AM, the surveyors continued the tour with FSD. The surveyor observed a single door, white reach in freezer and identified several opened foods with no opened date and were not labeled. The FSD identified the following items and stated that, "items should have been labeled and dated." -Two plastic bags of cooked yellow rice on the door shelf, which had no label and no date indicating when it was cooked. -Cooked chicken cutlets in a plastic bag on the door shelf, which had no label and no date indicating when it was cooked. -An opened bag of vegetables, with no date indicating when it was opened. -A piece of salmon wrapped in clear plastic wrap, with no date. -A plastic bag of cooked white rice on the door shelf, which had no label and no date indicating when it was cooked. -An opened bag of frozen blueberries with no opened date. -Two opened plastic bags of hashed brown potatoes, with no opened date. -An opened plastic bag of French fries, with no opened date. -An opened plastic bag of chicken tenders, with	F 812	-Dietary staff were in service how to remove and handle items from the dishwasher. -Dietary staff were in-service by Registered Dietitian appropriate food storage policy and proper labeling policy, proper food handling, sanitation on kitchen environment and equipment policy. -Inservice on maintaining accurate temperature lon in dishwasher machine and refrigerators. -Personal items found on the metal shelf next to the food items were removed and dietary staff where in-service no personal items are to be stored in the kitchen area. -The dirty items that were placed in the clean shelf of the clean pot rack were removed and the clean pot rack was sanitized. -Dietary staff were re-educated in hand hygiene policy when handling clean dishes. -Dietary staff were in service to record in the accountability log the chemical strength of the sanitizer in a 3-sink compartment. -The debris on the four-slice toaster/two slice toaster were removed and cleaned.	

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F 812	Continued From page 25 no opened date. -Three opened plastic bags of fish sticks, with no opened date. -A "meat like" item wrapped in plastic, which had no label and no opened date. The FSD was unable to identify the item. -A ring of sweet Italian sausage wrapped in plastic, with no opened date. -An opened plastic bag of hamburger buns, with no opened date. -An opened plastic bag of French toast, with no opened date. At 10:38 AM, the surveyor observed a double door, stainless steel, reach in refrigerator which had an external digital thermometer that displayed "DEF" and not a numerical value. The FSD and Cook were unable to locate an internal thermometer to verify the refrigerator temperature. The surveyor identified the following: -An opened half golden yellow sheet cake with white icing, loosely covered in plastic, with no opened date. -An opened container of Cocktail sauce, with an opened date of 2/17/2023 (once opened and refrigerated this product is good for six months as per the USDA website FoodSafety.gov). -A 15 ounce (oz) opened glass jar of [name redacted] Alfredo Sauce, which had no opened date.	F 812	-The flat mop stored in direct contact to the kitchen was removed and stored in different location outside the kitchen area. -Dry storeroom - items that were removed dry storage area to ensure that dry storeroom less than 18 inches from the ceiling. Dietary staff were in- service for the proper storage. All dietary staff were in service on the following policies: 1. Labeling and Dating 2. Staff food storage 3. Discarding food items 4. Cleaning dishes/ Dish machine 5. Three Compartment Sink 6. Cleaning Kitchen Floor 7. Food Brought Outside Sources Identification All residents have the potential to be affected by this deficient practice. Systemic Changes Monthly audits will be done by Registered Dietitian/Designee on the following: 1) sanitation in food storage area and kitchen environment. Maintaining the same ares in a sanitary manner. 2) proper food storage and labeling of food items; checking on expiration dates of the food items	

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F 812	Continued From page 26 -An opened bottle of Mustard, with no opened date. -An opened half gallon container of Almond milk, with no opened date. The FSD stated, "it was opened this morning," and the Cook stated, "I was late, and I did not have time to date it." -A 32 oz opened container of Coconut milk, with no opened date. -An opened plastic bag of pre-sliced [name redacted] sweet rolls, with no opened date. -An opened plastic bag of Parmesan cheese, with no opened date. -Four pieces of cake on a round white plate and wrapped with clear plastic wrap, with no prepared date. -Tortilla shells wrapped in clear plastic wrap, out of the original package, with no opened date. -An opened plastic bag of Romaine lettuce with no opened date. The FSD stated, "I did not purchase it. I think it's been here from before I started the job." -An opened one-gallon container of apple juice, with no opened date. -A large amount of red meat in a deep pan, which was placed on the bottom shelf and wrapped in clear plastic. It was not labeled or dated. The FSD stated, "it seemed like it had freezer burn but I put it there to thaw it. I wouldn't use it." The FSD could not speak to why he defrosted the	F 812	3) maintaining accurate temperature logs on Dishwasher machine and refrigerators. Monitoring A monthly QAPI will be done by Registered Dietitian/Designee on the following x3mos and quarterly thereafter on: 1. proper storage and labeling of food items which includes checking on expiration dates of the food items 2.Proper sanitation in food storage area, kitchen equipment and Kitchen environment. Maintaining food storage area, kitchen equipment and Kitchen environment in a clean and sanitary condition at all times 3. Maintaining accurate temperature logs in the Dishwasher and refrigerators	

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F 812	Continued From page 27 meat if he did not intend to use it. -Cooked pork in a plastic bag, with an opened date of 11/5/23. The FSD stated that it was "good for two weeks, its cooked. I won't keep it past seven days" and then placed it back in the refrigerator. (Once opened and refrigerated this product is good for seven days as per the USDA website FoodSafety.gov) -Meat loaf wrapped in foil, which had no date indicating when it was cooked. -An opened 4.5 oz container of sweet and sour sauce, with no opened date. -A bowl of cooked black beans and rice covered with clear plastic and dated 11/11. -Raw seasoned chicken in a small restaurant pan, covered with clear plastic and marked with a prepared date of 11/13 (raw chicken is good for one to two days refrigerated as per the USDA website FoodSafety.gov). -A round container filled with a "beige like" product. The container was not labeled or dated. The Cook stated, "the food belongs to staff," and the FSD acknowledged, "it should not be stored in the kitchen refrigerator, that they (the staff) have their own refrigerator." At 11:05 AM, the surveyor observed a 10.5 oz container of collagen peptides (dietary supplement), with an expiration date of 10/2023, stored on a metal shelf next to food. The FSD stated, "I think its someone's personal item and it should not be stored here next to food."	F 812		

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F 812	Continued From page 28 The surveyor observed breadcrumbs in a plastic container (out of the original package) which was not dated. The surveyor observed silverware (forks and knives) in a plastic container that was in direct contact with the floor. The FSD stated, "It shouldn't be stored on the floor." At 11:10 AM, the surveyor observed a metal rack with four shelve which contained large pans and pots. The FSD identified the shelving as a clean pot rack. In the middle of the bottom shelf, there was a large clear plastic bin which contained the following soiled items: a bread pan, a labeling gun, a black mixer, a silver tray, a soup bowl, and a saltshaker. The FSD stated, "it's all garbage." The surveyor observed a metal pan cover which was soiled on the bottom shelf of the rack. The FSD removed the pan cover from the shelf, showed the surveyor and acknowledged that "it was dirty" and placed it in the sink. The surveyor observed a large, soiled plastic tray on the bottom shelf of the rack. The FSD acknowledged that "it was dirty." The surveyor observed a 2-inch full-size stainless-steel hotel pans on the bottom shelf. The FSD stated there was, "dry blueberries and breadcrumbs stuck to the bottom" and acknowledge it was "dirty." The FSD stated, "The rack is for clean items and the garbage/soiled equipment should not be stored there." The surveyor observed a closed clear plastic container with multiple small packets wrapped in plastic, stored on a wall mounted metal shelf. The FSD opened them and identified the following: -An opened dry butterscotch pie filling/pudding mix, with no opened date.	F 812		

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F 812	Continued From page 29 -An opened dry banana cream pie instant pudding mix, with opened date 2/6/2023. The FSD stated, "It's good for 2-3 months, once its open." (Once opened this product is good for three-four months as per the USDA website FoodSafety.gov). The surveyor observed the following items stored on wall mounted metal shelves: -An opened package of bread, with no opened date. -A 30oz jar of grape jelly, with a best by date of 9/6/22. -An opened 20oz squeeze bottle of [name redacted] concord grape jelly, with no opened date. -An opened 16 oz container of peanut butter, with no opened date. -An unopened 12.75 oz glass jar of sugar free strawberry jam, with expiration date of 7/15/23. The FSD stated, they are "shelf stable product, it's not going to rot." At 11:26 AM, the surveyor observed eyedrops, keys, lip balm and a cell phone on the metal shelf next to food. The FSD acknowledged these items were the cook's personal belongings. The Cook stated, "I was late this morning, I put it up there." The FSD stated, "they should not be there next to food items." The surveyor also observed an opened 16 oz box	F 812		

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F 812	Continued From page 30	F 812		

of whole grain penne pasta, with no opened date. The FSD stated, "It is still good. I can tell by looking at it," and further stated, "this is not something I would use."

At 11:32 AM, the surveyor observed the cook remove clean items from the dishwasher with his bare hands. He touched the inside of a ladle and the inside of the small frying pan while he placed them on a hanging storage rack. The surveyor also observed the cook remove three white dinner plates from the dishwasher and place them inside the oven whereby his thumb was in direct contact with both sides of the plates. In addition, the surveyor observed the cook remove five plastic cups. The surveyor did not observe the cook perform hand hygiene prior to removing the clean dishes out of the dishwasher. The Cook acknowledged that he did not wash his hands and stated, "we don't have to use gloves." The FSD stated, "[name redacted] hands are clean, and he did not touch the glasses from inside."

At 11:40 AM, the surveyor observed shelves which contained ingredients and observed the following:

-An opened 16 oz bottle of Imitation Vanilla, with no opened date.

-An opened 32 oz container of canola oil, with no opened date.

-An opened six-pound (lbs.) container of extra light amber honey, with no opened date.

-An unrefrigerated opened bottle of teriyaki sauce, with an opened date of 3/4/2023. (Once opened, this product is good for one month if

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refrigerated after opening as per the USDA website FoodSafety.gov).

-An opened one-gallon container of molasses, with an opened date of 11/20/2019 and a best if used by date of 7/6/2023.

-An opened one-gallon container of white cooking wine, with no opened date.

-Two unrefrigerated, two-quart size opened containers of soy sauce with opened dates of 9/5/2022. The FSD stated it was still good, "due to the salt component in this, I give it 18 months to 2 years." (Once opened this product is good for one month if refrigerated after opening as per the USDA website FoodSafety.gov)

-An opened one-gallon container of beef consommé base, with an opened date of 7/25/2021. The FSD stated, "I wouldn't use it."

-An opened 128 oz container of Worcestershire sauce, with an opened date of 8/18/2021 and best if used by date of 5/21/2022.

At 11:40 AM, the surveyor observed a three-compartment sink. The Cook tested the chemical strength for the sanitizer, which was 200 parts per million (ppm) but did not record the concentration on an accountability log. The cook stated, they do not record the sanitizer strength.

The surveyor observed a four-slice toaster, with dried debris on top, stored near shelf stable ingredients. The FSD stated, "they don't use it. But still its dirty." The surveyor also observed a two-slice toaster. The FSD stated there was "boiled/dried grease" on top.

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F 812	Continued From page 32 At 11:55 AM, the surveyor observed a flat mop stored in direct contact with the kitchen floor next to the handwashing sink. The FSD stated it "should not be stored face down. It will never dry." At 12:07 PM, the surveyor observed boxes stored on the top shelves in the dry storeroom less than 18 inches from the ceiling and sprinkler heads. The FSD stated, "the boxes should be six inches from the ceiling and six inches from the floor." The surveyor observed multiple five-pound tubs of peanut butter which had no received date or best by use date. At 12:11 PM, the surveyor observed three plastic bags of walnuts in the dry storage room. The FSD stated, "they were approximately two pounds each with an expiration date of 6/22/23." At 12:23 PM, the surveyor observed a small refrigerator/freezer unit in the resident dining room. The FSD stated, "it is the resident's refrigerator to store their personal foods." The surveyor observed a sign posted on the refrigerator which indicated, "Resident food only. Food from families must have resident name and date. If not dated will be thrown out after three days. Not for employee use." The surveyor did not observe temperature logs. The FSD acknowledged "there is no temperature logs and no thermometer in the refrigerator or freezer. This is the first time I opened this refrigerator." The surveyor identified several foods with no name or dates marked on them as follows: - An aluminum bread pan with a hard plastic cover which contained a baked good. There was	F 812		

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no name or date on it.

- An opened 52 oz container of lemonade with no opened date or name on it. The surveyor observed a best by use date of 10/30/2023 on the container.

- A brown colored box with piece of leftover cake, with no date.

At 12:27 PM, the surveyor observed an opened half gallon container of butter pecan ice-cream stuck to the freezer, with no name or opened date. The surveyor observed a brown colored sticky substance on the bottom of the freezer. The FSD stated, "it looks like its melted ice cream." The FSD stated, "I don't think anyone checks the temperatures but it's going to be me checking it."

Review of the facility policy "Food Safety and Sanitation" reviewed 6/2/2023, included "all local, state and federal standards and regulations will be followed in order to assure a safe and sanitary department of food and nutrition services." It also included the following:

-"Refrigerated food is stored at or below 41 degrees Fahrenheit (F)"

-"Food stored in dry storage is placed on clean racks at least ...18 inches from the ceiling ..."

-"All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored."

-"When a food package is opened, the food item should be marked to indicate the open date. This

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date is used to determine when to discard the food."

-"Leftovers are used within 72 hours (or discarded).

-"Perishable food with expiration dates is used prior to the use by date on the package."

-"Canned and dry food without expiration dates are used within six months of delivery or according to the manufacturers guidelines."

Review of the facility policy "Labeling and Dating" dated 4/18/2023, included "all food received in the building, dry, dairy, refrigerated or frozen, must have a "received date." It also included, "all prepared foods are dated the date they are made and counting as day one. Must have a "use by" date. Example- Egg salad made 1-15-17 use by 1-17-17. This procedure is followed for all prepared foods: egg salad, puddings, applesauce, desserts, salads, etc. All foods prepared in the kitchen must be dated with a "use by" date and discarded in three days." In addition, it included items once opened "must be dated with open date."

Review of the facility policy "Staff Food Storage" dated 5/20/23, included there is a refrigerator for employee food only and all food must be labeled with a name and date. All items will be discarded after 72 hours.

Review of the facility policy "Discarding Food Items" dated 6/29/2023, included "all food items that are prepared by the facility will be discarded within 72 hours (3 days)." It also included "all items that are packaged by the manufacturer ...

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must be dated when opened."

Review of the facility policy "Cleaning Dishes/Dish Machine" dated 5/18/2023, included clean hands or gloves should be used when clean dishes are removed from the dish machine.

Review of the facility policy "Three Compartment Sink" dated 4/25/2013, included check the sanitizing compartment sink for the proper chemical dilution using the test strips. Note and initial the dilution on the monitoring form. It also included the dilution must be checked each time you re-fill the rinse compartment.

Review of the facility policy "Cleaning, Kitchen Floor (Mopping)" reviewed 5/21/23, included "return the clean bucket and mop to designated storage area."

Review of the facility policy "Foods Brought in from Outside Sources" reviewed 5/2022, included foods items should be labeled with the resident's name, date the item(s) were purchased or prepared and the name of the item. It further included, "perishable foods that require refrigeration will be discarded after 72 hours (3 days) of the food is not consumed by the resident."

Review of the undated facility job description for "Cook," included the following:

-"Discards outdated food from the refrigerators."

-"Check food supplies, kitchen supplies, ... and ensures that cooking utensils, pans, and other equipment are kept in a clean/sanitary condition."

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F 812	Continued From page 36 -"Employees should not have any food, drink, or any personal items (such as key, coats, bags, backpack, wallets, purses, etc.) in the kitchen."	F 812		
F 851 SS=F	NJAC 8:38-17.2 (g) Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed	F 851		12/15/23

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	315409	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	1 SUMMIT AVENUE NEWTON, NJ 07860

(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 851	Continued From page 37 practical nurse, licensed vocational nurse, certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to submit their Payroll Based Journal (PBJ) Report to the Centers for Medicare and Medicaid Services (CMS) within a timely manner. This deficient practice was identified for one of three PBJ Report submissions reviewed, (Fiscal Year Quarter 3 2023, April 1 - June 30) and was evidenced by the following:	F 851	Specific Corrective action Administrative Assistant (AA) was in service regarding timely submission of the Payroll Base Journal (PBJ) A policy for PBJ submission was updated to have payroll zip files prepared by payroll company will be submitted on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING _____ B. WING _____	C 11/22/2023

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F 851	Continued From page 38 A review of the PBJ Staffing Data Report CASPER Report 1705D reflected a triggered area that the facility failed to submit data for the third fiscal year quarter to CMS. The dates of the third quarter included April 1, 2023, through June 30, 2023. On 11/20/23 at 12:09 PM, the surveyor interviewed the Administrative Assistant (AA) in presence of a second surveyor. She stated, she was responsible for the nursing staff scheduling as well as reporting staffing daily to the Department of Health (DOH) website. On 11/21/23 at 10:25 AM, the surveyor interviewed the AA, who stated that she submitted staffing to the DOH daily and to CMS on a quarterly basis. She stated staffing must be submitted to CMS quarterly. She further stated, she submitted for the quarter 7/1/23 through 9/30/23, but not for 4/1/23 to 6/30/23. The AA stated, at that time it was someone else's responsibility. On 11/22/23 at 9:32 AM, the AA stated she could not provide a CMS validation for staffing reported for the 3rd quarter of 4/1/23 to 6/30/23. On 11/22/23 at 10:04 AM, the surveyor interviewed the AA in the presence of the survey team. She stated that she submitted staffing for the third quarter 4/1/23 to 6/30/23, on the deadline of 8/14/23. The AA further stated on [redacted], she resubmitted the staffing due to an emailed received which indicated something "did not go through." In addition, she stated she read "the manual" which indicated staff submission would not be accepted after the due date. She	F 851	biweekly basis and will be uploaded to CMS by the payroll clerk. "Submission form" Generated by CMS with each submission uploaded will be printed out by AA. AA will print out "Final Validation Report" to make sure it was accepted. Identification All resident has potential to be affected by this deficient. Systemic Changes Biweekly Audits will be done Administrator to ensure that payroll report was submitted by AA with a print out "Submission Form" Monitoring Quaterly audit done by Administartor to ensure that final submission PBJ is completed with the "Final Validation Report" 20 days before the deadline of the PBJ Submission to ensure timely submission and given time to the facility for any changes correction before the deadline.	

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F 851	Continued From page 39 provided the surveyor a copy of a validation report from CMS for the quarter staffing [redacted], which was blank. She acknowledged it was not submitted on time.	F 851		
F 880 SS=D	NJAC 8:39-41.3(a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		12/15/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING _____ B. WING _____	C 11/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	1 SUMMIT AVENUE NEWTON, NJ 07860

(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 880	Continued From page 40 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it	F 880	Specific Corrective action	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING _____ B. WING _____	C 11/22/2023

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F 880	Continued From page 41 was determined that the facility staff failed to follow appropriate infection control practices for appropriately performing hand hygiene and sanitizing a Ex Order 26. 4B1 between 2 of 2 residents observed during the medication pass, (Resident#5 and Resident #10). These deficient practices were evidenced by the following: On 11/17/23 at 8:35 AM, during the medication pass, the surveyor observed the Licensed Practical Nurse (LPN) obtaining Resident #10's vital signs. The LPN brought the electronic Ex Order 26. 4 [redacted] cuff into the resident's room and took the resident's Ex Order 26. 4B1. The LPN then returned to the medication cart which was in the hall. The surveyor observed the LPN placing the electronic Ex Order 26. 4B1 cuff on the medication cart. The surveyor did not observe the LPN sanitize the electronic Ex Order 26. 4B1 cuff or perform hand hygiene. The surveyor observed the LPN prepare medication for Resident #10 and then observed her entering the resident's room and administering the medications. After medication administration, then LPN was observed returning to the medication cart and signed off Resident #10's electronic medication administration record. The surveyor did not observed the LPN perform hand hygiene. On 11/17/23 at 8:44 AM, the surveyor observed the LPN pick up the electronic Ex Order 26. 4B1 cuff which was not sanitized and bring it into the facility's activity room to Resident #5. The surveyor observed the LPN tell Resident #5 that she will be taking the resident's vital signs and will then will administer the resident's medication. After taking Resident #5's Ex Order 26. 4B1, the	F 880	LPN was re-educated with Blood Pressure Equipment and Hand Hygeine policy. Identification All resident have potential to be affected by this deficient practice. Systemic Changes DON/Designee will conduct a monthly competencies to all licensed staff during med pass observation for blood pressure equipment cleaning in between residents during med pass and hand hygiene between residents during med pass observation Monitoring DON/Designee will do monthly QAPI for blood pressure equipment in between residents during med pass and hand hygiene during med pass observation x 3 months and quarterly thereafter. Report will be submitted to Administrator and will discussed during quarterly meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING _____ B. WING _____	C 11/22/2023

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F 880	Continued From page 42 surveyor observed the LPN return to the medication cart and without performing hand hygiene start to prepare Resident #5's medications. At that time, the surveyor interviewed the LPN, who acknowledge that she should have sanitized the electronic *Ex Order 26. 4B1* cuff prior to taking Resident #5's vital signs. The LPN further stated that she should have performed hand hygiene after administering Resident #10's medications. On 11/21/23 at 1:30 PM, the surveyor discussed the above findings with the Regional Licensed Nursing Home Administrator, the Director of Nursing (DON), and the Infection Preventionist. There was no additional information provided. A review of the facility's policy for "Blood Pressure Equipment Cleaning" that was dated 5/03/23 and was provided by the DON included the following: " To ensure that blood pressure machine is sanitize and clean after use in between residents to prevent cross contamination." A review of the facility's policy for "Hand Hygiene" that was dated 1/31/23 and was provided by the DON included the following: "Adherence to hand hygiene practices is maintained by all Center Personnel. This includes hand washing with soap and water when hands are visibly soiled and the use as alcohol-based hand rubs for routine decontamination in clinical situations." Under Process: "After contact with resident's intact skin."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING _____ B. WING _____	C 11/22/2023

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F 880	Continued From page 43 NJAC 8:39-19.4 (a) (1) (n) (2)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315409 Y1	A. Building B. Wing Y2	12/31/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	1 SUMMIT AVENUE NEWTON, NJ 07860

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 F0657	Correction	ID Prefix F0695	Correction	ID Prefix F0755	Correction
Reg. # 483.21(b)(2)(i)-(iii)	Completed	Reg. # 483.25(i)	Completed	Reg. # 483.45(a)(b)(1)-(3)	Completed
LSC	12/15/2023	LSC	12/15/2023	LSC	12/15/2023
ID Prefix F0801	Correction	ID Prefix F0812	Correction	ID Prefix F0851	Correction
Reg. # 483.60(a)(1)(2)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(q)(1)-(5)	Completed
LSC	12/15/2023	LSC	12/15/2023	LSC	12/15/2023
ID Prefix F0880	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/15/2023	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/22/2023	☐ 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)
315409	A. Building B. Wing	12/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	1 SUMMIT AVENUE NEWTON, NJ 07860

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0657 Reg. # 483.21(b)(2)(i)-(iii) LSC	Correction Completed 12/15/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 12/15/2023	ID Prefix F0851 Reg. # 483.70(q)(1)-(5) LSC	Correction Completed 12/15/2023
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	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON	
11/22/2023	☐ 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315409 Y1	A. Building B. Wing Y2	12/31/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	1 SUMMIT AVENUE NEWTON, NJ 07860

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0015 Reg. # 483.73(b)(1) LSC	Correction Completed 12/15/2023	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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

FOLLOWUP TO SURVEY COMPLETED ON 11/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	**1 SUMMIT AVENUE** **NEWTON, NJ 07860**

(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 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/22/2023 and Valley View Rehabilitation and Healthcare Center 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. Valley View Rehabilitation and Healthcare Center is a single (1) story, Type I Fire Resistant building that was built in January 1961. The facility is divided into 2 smoke zones and has a Diesel Emergency Generator.	K 000		
K 252 SS=D	Number of Exits - Corridors CFR(s): NFPA 101 Number of Exits - Corridors Every corridor shall provide access to not less than two approved exits in accordance with Sections 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. 18.2.5.4, 19.2.5.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview conducted on 11/22/2023, it was determined that the facility failed to provide at least 2 acceptable exits, remote from each other, for each floor or fire	K 252	Specific Corrective Action A location to create an emergency exit was identified the proposed location was	11/20/24

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

Electronically Signed | 12/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 252	Continued From page 1 section of the building as evidenced by the following: During the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with thirteen (13) Resident sleeping rooms divided into two (2) two smoke compartments and a basement. Starting at approximately 9:44 AM, in the presence of the MS, a tour of the building was conducted. At approximately 10:42 AM, the surveyor observed that 1 of 2 exits in the basement went through a laundry room. This exit was not a means of egress leading directly to the outside, but instead, went through a hazardous room, a laundry room, then to the outside. This finding was acknowledged and confirmed in an interview with the MS at the time of the surveyor's observation. The surveyor noted that the only entrance to the basement was through a door located on the first floor that was locked with a coded keypad device located next to the door. Only staff had access to the code. This information was verified by the surveyor during the tour of the basement. At approximately 1:15 PM, the surveyor informed the facility DON, MS and Facility Consultant of the deficiency during the Life Safety Code survey	K 252	submitted to the department of health on the previous plan of correction we have created a plan and is now submitting this drawing to the state/DCA for approval expected Date of submission will be 12/29/2023 and once approval is received, and permit granted work will commence. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes An approval is now being sought to install a new exit from DCA. Once approval is received the facility Consultant will seek a local township permit to start the work. Facility will conduct rounding every shift to ensure that residents, staff and visitors are safe during ongoing project maintaince staff will conduct rounding through out the building on 7-3 and 3-11pm shift and nursing will conduct shift conduct rounding throuthout the building on 11-7 shift Daily report will submitted to administrator/designee. Monthly QAIP will be done by Life Safety Consultant/Designee Monitoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	**1 SUMMIT AVENUE** **NEWTON, NJ 07860**

(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 252	Continued From page 2 exit. NJAC 8:39-31.2(e) NFPA 101:2012 - 19.2.5.4	K 252	A monthly follow-up with them will be done to see where in the approval process, we are. Monthly QAPI will be done by Life Safety Consultant/Designee regards to ensuring the Safety of Residents, Staff and Visitors by rounding every shift. Report will be submitted to Administrator/Designee and will discuss during the quartly meeting.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and review of facility provided documentation on 11/22/2023, in the presence of facility management, it was determined that the facility failed to provide two (2) illuminated exit signs to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where	K 293	Specific Corrective Action The Maintenance Department purchased two exit signs with battery Backup and directional arrow to be installed the hallway and will be visible from the lobby to clearly indicate what direction the exit door is these signs will be installed on or before December 29 the 2023. Identification All residents have the potential to be affected by the deficient practice.	12/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

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K 293	Continued From page 3 the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign." On 11/22/2023, during the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance Staff (MS) to provide a copy of the facility lay-out	K 293	Systemic Changes The life Safety consultant will do a monthly audit review on the daily checklist used in daily inspection to ensure that two exit signs are illuminated clearly in identifying exit access path to reach the exit discharge door. Life Safety code consultant will do a monthly visual walk-through inspection to ensure that the two signs are illuminated clearly in indentifying exit access path to exit discharge door. Monitoring Life safety code Consultant will do QAPI monthly will be conducted on all exit signs floors by the building Life safety consultant/designee to ensure that the exit signs are all in place and in compliance monthly x3 months and annually. The report will be submitted to the administrator and will be discussed during the quarterly meeting thereafter. The report will be submitted to the Administrator and discussed at a quarterly meeting.	

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K 293	Continued From page 4 which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with thirteen (13) Resident sleeping rooms divided into two (2) two smoke compartments. Starting at approximately 9:44 AM in the presence of the MS a tour of the building was conducted. During the building tour of the facility, the surveyor observed two (2) locations that failed to have illuminated exit signs to clearly identify the exit access route to reach an exit in the following locations, 1) At approximately 9:55 AM, the surveyor observed that the facility failed to have one (1) illuminated exit sign above the corridor smoke door (next to the Activities room). 2) At approximately 10:58 AM, the surveyor observed in the corridor, near Resident room #7 towards the lobby, that the facility failed the have one (1) illuminated exit sign with a directional arrow to lead you to the designated exit discharge lobby door. A review of an emergency evacuation diagram posted in the corridor identified this is the primary and/or secondary exit access route to reach an exit discharge door. The facility MS confirmed the findings at the time of observations. At approximately 1:15 PM, the surveyor informed	K 293		

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K 293	Continued From page 5 the facility DON, MS and Facility Consultant of the deficiency during the survey exit. Fire Safety Hazard. NFPA Life Safety Code 101 2012 -7.7 NFPA 101:2012- 19.2 Means of Egress Requirements NJAC 8:39 -31.1 and 8:39 -31.1 (c) NFPA Life Safety Code 101 2012 -7.7	K 293		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on interview and documentation review on 11/22/2023, in the presence of the facility management, and document review on 12/01/2023 (post-survey), it was determined that the facility failed to 1) Ensure smoke detection sensitivity was checked every alternate year of the facility smoke detectors, 2) Conduct semi-annual testing of the fire alarm and detection system, in accordance with NFPA 72 National Fire Alarm and Signaling Code (2010 Edition Section 14.4.5.3.2. This deficient practice was identified for 1 of 1 fire alarm systems and was evidenced by the following:	K 345	Specific Corrective Action The Facility Life safety consultant (LSCC) has scheduled a second Fire alarm system test for the year 2023 to include smoke sensitivity test, this test is expected to be completed on or before December 29,2023 Identification All residents have the potential to be affected by the deficient practice.	12/29/23

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K 345	Continued From page 6 On 11/22/2023, during the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance Staff (MS) to provide all mandatory inspections that had been conducted from 01/01/2022 through 11/21/2023 for review later. The surveyor also requested the facility to provide a copy of the last smoke detectors sensitivity testing. Later at approximately 11:25 AM, a review of the facility provided mandatory inspections for the previous 22-1/2 months was performed. The surveyor reviewed the following Fire Alarm and Detection system inspections: - 10/07/2022 semi-annual inspection. - 05/08/2023 semi-annual inspection. This review of the testing reports revealed no reference to a smoke detection sensitivity testing. The facility conducted one semi-annual inspection for 2022. At approximately 12:42 PM on 11/22/2023, the surveyor asked the facility Consultant and MS that they may have to call the fire alarm and detection vendor and ask for a copy of the last smoke detector sensitivity testing, any other semi-annual inspections for 2022, and to provide the copy of the smoke detector sensitivity testing and semi-annual inspection to the surveyor by way of email to the surveyor, no later then 12/01/2023 (post-survey), for review. On 12/01/2023 (post-survey), the facility Consultant provided, via-email, a copy of the	K 345	Systemic Changes 1. The facility Life Safety consultant will do a bi-annual audit to ensure that smoke detection sensitivity will be checked every alternating year of the facility alternating year. 2. The Life Safety Consultant will do a semi-annual audit to ensure that Fire Alarm Company conducted semi-annual testing of the fire alarm and detection system. Monitoring The LSCC will do a QAPI to ensure that smoke detection sensitivity will be checked every alternating year of the facility alternating year and audit to ensure that Fire Alarm Company conducted semi-annual testing of the fire alarm and detection system every 3 months x3 and every 6 months thereafter. The report will be submitted to the administrator and will be during a quarterly meeting.	

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K 345	Continued From page 7 10/07/2022 (duplicate semi-annual inspection) fire alarm and detection system semi-annual inspection. The smoke detector sensitivity testing of the fire alarm and detection system had not been done and the facility conducted one semi-annual inspection of the fire alarm and detection system for the year 2022. NJAC 8:39-31.1(c), 31.2(e) NFPA 70, 72	K 345		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler 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, interview and review of facility provided documentation on 11/22/2023, in	K 351	Specific Corrective Action	1/30/24

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K 351	Continued From page 8 the presence of facility management it was determined that the Facility failed to install sprinklers, as required by CMS regulation §483.90(a) physical environment to all areas in accordance with the requirements of NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. The deficient practice is evidenced by the following, On 11/22/2023, during the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility as a single-story building with thirteen (13) Resident sleeping rooms divided into (2) two smoke compartments and a basement with one stairwell. Starting at approximately 9:44 AM, in the presence of the MS, a tour of the building was conducted. Along the tour at approximately 10:50 AM, the surveyor observed no evidence of fire sprinkler coverage inside the approximately 14'-6" by 6' stairwell lower landing. At this time the surveyor asked the MS if he saw a sprinkler, the MS looked around and said, "No." The MS confirmed the finding at the time of observation.	K 351	Sprinkler company was contracted to install additional sprinkle under the lower level Stairwell 14'-6" by 6 lower landing we are awaiting scheduling of this work to be done as per the conversation with sprinkler company this work should be done before january 30 2023 Identification All residents have the potential to be affected by the deficient practice. Systemic Changes The facility Life Safety consultant will be task to examine all ares of the building to see if there is any location that may not be properly covered by sprinkler system and all those areas will be contracted out to sprinkler company to bring into compliance a report will be generated maintained and shared with the facility administrator. Monitoring A QAPI will be done by the LSCC/Designee quarterly x3 to ensure all areas of the building are covered and the necessary work of none covered area i.e. stairwell lower landing and annually thereafter. The report will be submitted to the administrator and will be discuss at a quarterly meeting.	

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K 351	Continued From page 9 At approximately 1:15 PM, the surveyor informed the facility DON, MS and Facility Consultant of the deficiency during the Life Safety Code survey exit. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ 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 observation, interview and record review on 11/22/2023 in the presence of facility management and record review on 12/01/2023 (post-survey) , it was determined that the facility failed to comply with the inspection and testing requirements NFPA 25 as evidenced by the	K 353	Specific Corrective Action The Facility Life safety consultant (LSCC) will now be responsible for ensuring that the quarterly inspection for the sprinkler system will be done quarterly in a timely	12/29/23

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K 353	Continued From page 10 following: On 11/22/2023, during the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance Staff (MS) to provide all mandatory inspections that had been conducted from 01/01/2022 through 11/21/2023 for review later. Starting at approximately 9:44 AM, in the presence of the facility MS, a tour of the building was conducted. Along the tour at approximately 10:45 AM, an inspection in the basement, where the fire sprinkler control valves were located, was performed. The surveyor observed on the inspection tag attached the the sprinkler control valves with the following dates of quarterly (every 3 months) conducted, - January 2023, April 2023 and November 2023. Later at approximately 11:25 AM, during the documentation review of the mandatory inspections of the facility's quarterly (every 3 months) fire sprinkler system inspections for the previous 22 months identified the system had the following quarterly sprinkler system inspection reports: - 2/08/2022, 5/05/2022 and 10/18/2022. - 1/06/2023, 4/25/2023, 8/17/2023 and 11/03/2023. At approximately 12:42 PM on 11/22/2023, the surveyor asked the facility Consultant and MS if there were any other quarterly (every 3 months)	K 353	manner. Identification All resident have the potential to be affected by the deficient practice. Systemic Changes 1. The Life Safety Consultant will do a quarterly audit to ensure that the quarterly sprinkler inspection and testing are done in a timely manner. LSCC will do quarterly tag visual inspection on the sprinkler valve to ensure that the actual dates of inspection were accurately documented. Monitoring A quarterly QAPI will done by LSCC to ensure that quarterly sprinkler testing and inspection are done in a timely manner and the inspection tags were updated accurately reflecting the actual dates of inspections x4. Reports will be submitted to the administrator and will be discussed during the quartely meeting.	

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K 353	Continued From page 11 sprinkler system inspections and to provide the reports to the surveyor, no later then 12/01/2023 (post-survey) for review. On 12/01/2023 (post-survey), the facility Consultant provided, via-email, the following copies of Quarterly sprinkler system inspections for: - 2/08/2022, 5/05/2022 and 10/18/2022. - 1/06/2023, 4/25/2023, 8/17/2023 and 11/03/2023. The facility did not conduct a quarterly fire sprinkler system inspection between 05/05/2022 and 10/18/2022. The facility failed to conducted four (4) quarterly sprinkler inspection for the year 2022 as required per NFPA 25. NJAC 8:39-31.2(e) NFPA 25	K 353		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 11/22/2023 in the presence of facility management, it was determined that the facility failed to: Perform a monthly visual examination inspection for 5 of 13 portable fire extinguishers, Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA)	K 355	Specific Corrective Action Maintenance staff was in-service to perform a monthly visual examination on portable fire extinguisher and maintenance inspection. Actual inspection dates must be recorded in the tag	12/29/23

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K 355	Continued From page 12 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3 and N.J.A.C. 5:70. Reference #1 NFPA 10 Edition 2010 Standard for portable fire extinguishers reads: - 4-3 Inspection Maintenance. - 4-3.1 Frequency. Fire extinguishers shall be inspected when initially placed in service and there after at approximately 30-day intervals. Fire extinguishers shall be inspected at more frequent intervals when circumstances require. - 4-3.3 Corrective Action. When an inspection of any fire extinguisher reveals a deficiency in any conditions listed in 4-3.2 (a), (b), (h), and (i), immediate corrective action shall be taken. - 4-3.4 At least monthly, the date the inspection was performed and the initials of the person performing the inspection shall be recorded at least monthly and that records shall be kept on a tag or label attached to the fire extinguishers. - 7.3.1.1.1 Fire extinguishers shall be subjected to maintenance at intervals of not more than 1 years at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. The findings include the following: On 11/22/2023, during the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility is a single-story building with thirteen (13) Resident sleeping rooms divided into two (2) smoke compartments and a basement.	K 355	attached to the fire extinguisher. A checklist and location of all Fire extinguisher in the facility was created by LSCC for the maintenance to use ensuring all locations of the portable. The Facility Life Safety Consultant has created a checklist and location of all Fire extinguishers in the facility to ensure all locations of the portable extinguisher are identified for the monthly visual inspection. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes LSCC/Designee will do a monthly audit on portable fire extinguisher inspection and maintenance to ensure that it meets the standards in accordance with NFPA 10 Monitoring Monthly QAPI will be done by LSCC/Designee to ensure that portable fire extinguisher inspection is done in timely manner and that inspection is recorded in the tag attached to the fire extinguisher x3mos and quarterly thereafter.Report will be submitted to the administrator and discussed during the quarterly meeting.	

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K 355	Continued From page 13 Starting at approximately 9:44 AM in the presence of the MS, a tour of the building was conducted. During the building tour, the surveyor observed and inspected thirteen (13) portable fire extinguishers that were last annually inspected April 2023 in various locations. The surveyor observed 5 fire extinguishers with the following issues that were identified: 1) At approximately 10:10 AM, inside the first floor boiler room, one (1) BC-type fire extinguisher was last annually inspected in April 2023 with no evidence of a monthly visual examination performed and documented on the tag attached to the fire extinguisher for May, June, August, September and October 2023. 2) At approximately 10:37 AM, inside the lower level Kitchen dry storage room, the one (1) ABC-Type fire extinguisher was last annually inspected in April 2023 with no evidence of a monthly visual examination performed and documented on the tag attached to the fire extinguisher for August, September and October 2023. 3) At approximately 10:42 AM, one (1) ABC-Type fire extinguisher in the basement Commercial Laundry room was last annually inspected in April 2023 with no evidence of a monthly visual examination performed and documented on the tag attached to the fire extinguisher for August, September and October 2023. 4) At approximately 10:44 AM, one (1) ABC-Type fire extinguisher in the basement	K 355		

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	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	**1 SUMMIT AVENUE** **NEWTON, NJ 07860**

(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 355	Continued From page 14 Office was last annually inspected in April 2023 with no evidence of a monthly visual examination performed and documented on the tag attached to the fire extinguisher for August, September and October 2023. 5) At approximately 11:02 AM, one (1) ABC-Type fire extinguisher next to Resident room 10 was last annually inspected in April 2023 with no evidence of a monthly visual examination performed and documented on the tag attached to the fire extinguisher for August, September and October 2023. The facility's MS confirmed the findings at the time of observations. At approximately 1:15 PM, the surveyor informed the facility DON, MS and Facility Consultant of the deficiency during the Life Safety Code survey exit. NFPA 10 NJAC 8:39 -31.1 (c), 31.2 (e).	K 355		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.	K 372		12/8/23

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	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

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K 372	Continued From page 15 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 11/22/2023, it was determined that the facility failed to maintain the integrity of smoke barrier partitions for one (1) of one (1) smoke barrier wall inspected as evidenced by the following: On 11/22/2023, during the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility as a single-story building with thirteen (13) resident sleeping rooms divided into two (2) two smoke compartments. Starting at approximately 9:44 AM in the presence of the MS a tour of the building was conducted. The surveyor observed a smoke barrier wall which failed to maintain the 1/2 hour fire rated construction as required by code. At approximately 10:47AM, an inspection above the corridor ceiling tiles of the smoke door (next to the Activities room) identified an approximately 2" by 2" penetration through the smoke barrier wall. This penetration was observed on both sides	K 372	Specific Corrective Action All smoke Barrier walls were inspected and all penetration that was found was sealed with 3m Red Fire Barrier CP 25WB plus sealant completed 12/8/2023 Identification All resident have the potential to be affected by the deficient practice. Systemic Changes The maintenance staff will be task to check after each contractor who enters the building to do work to ensure that they don't breach any fire barrier walls and not seal them the Life Safety Consultant will inspect all fire walls on a quarterly basis for the next 4 quarter and check for breaches. Monitoring A quarterly QAPI will be done by LSCC/Designee x4 and annually on the fire barrier doors and barrier walls to ensure that there is no breach in any fire barrier walls to ensure compliance. The report will be submitted to the	

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	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

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K 372	Continued From page 16 through the smoke barrier wall, indicating that it was not sealed closed to prevent smoke, fumes and fire from passing through to the other smoke compartment. The facility MS confirmed the findings at the time of observations. At approximately 1:15 PM the surveyor informed the facility DON, MS and Facility Consultant of the deficiency during the Life Safety Code survey exit. Fire Safety Hazard. NJAC 8:39- 31.2(e).	K 372	administrator and will be discussed at the quarterly meeting.	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on an observation on 11/22/2023, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 3 electrical outlets located next to a water source (with-in 6 feet) was equipped with Ground-Fault Circuit Interrupter (GFCI) protection. This deficient practice was evidenced by the following:	K 911	Specific Corrective Action The Maintenance department has now installed Duplex GFCI outlet by sink in the Hair salon and now all outlets next to water source are fully GFCI protected. Identification All residents have the potential to be	12/8/23

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	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	**1 SUMMIT AVENUE** **NEWTON, NJ 07860**

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K 911	Continued From page 17 Reference: National Fire Protection Association (NFPA) 101, 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 210.8 Ground-Fault Circuit-Interrupter Protection for Personal, Ground-fault circuit-interruption for personal shall be provided as required in 210.8 (A) through (C). The ground-fault circuit-interrupter shall be installed in readily accessible location. (B) Other than Dwelling Units. All 125-volt, single phase, 15- and 20- ampere receptacles installed in locations specified in 210.8 (B) (1) through (8) shall have ground-fault circuit-interrupter protection for personal. (5) Sinks-- where receptacles are installed within 1.8 M (6 feet) of the outside of a sink. On 11/22/2023 during the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance Staff (MS) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. A review of the facility provided lay-out identified the facility as a single-story building with thirteen (13) resident sleeping rooms and common areas that are divided into two (2) two smoke compartments. Starting at approximately 9:44 AM in the	K 911	affected by the deficient practice. Systemic Changes The Maintenance staff will do a monthly audit to check all GFCI outlets to see that all electrical outlets next to a water source (within 6 feet) were equipped with Ground Fault Circuit Interrupter (GFCI) protection. Monitoring A monthly QAPI will be done by LSCC/designee x3months and quarterly thereafter to ensure that all outlets next to water source are functional and is protected by GFCI. The report will be submitted to the Administrator and will be discussed during the quarterly meeting.	

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	315409	A. BUILDING **01** B. WING _____	**11/22/2023**

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VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	**1 SUMMIT AVENUE** **NEWTON, NJ 07860**

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K 911	Continued From page 18 presence of the MS, a tour of the building was conducted. During the building tour with the MS, the surveyor observed and tested three (3) electrical outlets in wet (with-in 6 feet of a sink) locations with one (1) electrical outlet that failed to de-energize when tested in the following location, 1. At approximately 10:15 AM, an inspection inside the Physical Therapy/ Resident salon area identified one Duplex electrical outlet located four feet eight inches (4'-8") to the right of the hair washing sink when tested with a GFCI tester to de-energize, the Duplex electrical outlet did not de-energize as required by code. The facility MS confirmed the findings at the time of observations. At approximately 1:15 PM the surveyor informed the facility DON, MS and Facility Consultant of the deficiency during the Life Safety Code survey exit. NJAC 8:39 -31.2 (e) NFPA 99: -6.3.2.1, NFPA 70: -210.8	K 911		
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.	K 918		1/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 918	Continued From page 19 Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/22/2023 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator's was installed in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice was evidenced by the following: On 11/22/2023 during the survey entrance at approximately 9:31 AM, a request was made to the Director of Nursing (DON) and Maintenance	K 918	Specific Corrective Action A remote manual stop station will be installed by the Generator Company. A work order was obtained. Identification All residents have the potential to be affected by the deficient practice. Systemic Changes	

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K 918	Continued From page 20 Staff (MS) to provide a copy of the facility lay-out which identified the various rooms and smoke compartments in the facility. The MS told the surveyor that the facility had an emergency generator. Starting at approximately 9:44 AM in the presence of the MS a tour of the building was conducted. Along the tour at approximately 10:40 AM, an inspection of the emergency generator was performed. The surveyor observed no evidence of a remote manual emergency stop button. At this time same time, the MS stated that the facility did not have a remote manual emergency stop for the generator. The facility MS confirmed the findings at the time of observations. At approximately 1:15 PM the surveyor informed the facility DON, MS and Facility Consultant of the deficiency during the survey exit. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	A monthly test will be conducted to ensure the remote manual stop station is operational by Maintenance staff. Monitoring A QAPI will be conducted by LSCC/designee to ensure the remote manual stop station will prevent inadvertent or unintentional operation for the emergency generator monthly x3 months and quarterly thereafter. The report will be submitted to the Administrator to be discussed at quarterly meeting.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315409 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR	1 SUMMIT AVENUE NEWTON, NJ 07860

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 K0252	12/29/2023	LSC K0293	12/29/2023	LSC K0345	12/29/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	01/30/2024	LSC K0353	12/29/2023	LSC K0355	12/29/2023
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	12/08/2023	LSC K0911	12/08/2023	LSC K0918	01/30/2024
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 ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/22/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO