DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		· · ·	E SURVEY PLETED
		315409	B. WING		10	/08/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	VIEW REHABILITATION A	ND HEALTHCARE CTR		1 SUMMIT AVENUE NEWTON, NJ 07860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	Standard Survey: 10	/8/19				
	Census: 22					
F 640 SS=D		g Resident Assessments (4)	F 640	)		10/28/19
	§483.20(f) Automated requirement- §483.20(f)(1) Encodir a facility completes a facility must encode t each resident in the fa (i) Admission assessment (ii) Annual assessment (iii) Significant change (iv) Quarterly review a (v) A subset of items reentry, discharge, ar (vi) Background (face is no admission assess §483.20(f)(2) Transm after a facility comple a facility must be cap CMS System informa contained in the MDS standard record layou and that passes stand CMS and the State. §483.20(f)(3) Transm 14 days after a facility assessment, a facility	d data processing ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, nd death. e-sheet) information, if there ssment. itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident b in a format that conforms to uts and data dictionaries, dardized edits defined by ittal requirements. Within y completes a resident's must electronically transmit nd complete MDS data to				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE		(X6) DATE
	cally Signed					10/30/2019

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE	0. 0938-039 SURVEY LETED
		315409	B. WING			10/	08/2019
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	00/2013
VALLEY V	IEW REHABILITATION A	AND HEALTHCARE CTR			SUMMIT AVENUE		
	-			N	IEWTON, NJ 07860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page	e 1	F	640			
	(i)Admission assessr	nent.					
	(ii) Annual assessme	nt.					
		e in status assessment.					
	<ul> <li>(iv) Significant correct</li> <li>(v) Significant correct</li> </ul>	tion of prior full assessment.					
	assessment.						
	(vi) Quarterly review.						
	( )	s upon a resident's transfer,					
	reentry, discharge, a						
		ce-sheet) information, for an MDS data on resident that					
	does not have an ad						
	§483.20(f)(4) Data fo	rmat. The facility must					
		ormat specified by CMS or,					
		an alternate RAI approved					
	•	at specified by the State and					
	approved by CMS. This REQUIREMEN	Γ is not met as evidenced					
	by:						
		and record review, it was			Corrective Action		
		acility failed to complete and			1.Resident #1 Discharged MDS was		
	transmit a Minimum I	eral guidelines. This deficient			completed and transmitted on 2.Resident #2 Discharged MDS was		
		d for 2 of 14 residents			completed and transmitted on		
		assessment (Resident #1,					
	, ,	ractice was evidenced by the			Interdisciplinary Team were re-educate	ed	
	following:				with regards to timely completion and submission of the MDS in accordance		
	On 10/2/19 at 1:14 P	M, the surveyor conducted			with the federal guidelines.		
		Assessment Task which					
	• •	signated residents' MDS			Identification		
	Assessments.				All residents have the potential to be		
	The MDS is a compr	ehensive tool that is fodoral			affected by this deficient practice. MDS	5	
		ehensive tool that is federal or clinical assessment of all			audit will be done on all discharge residents to ensure that discharged MI	ns	
		e completed and transmitted			are completed and transmitted on a tin		
		re System. The facility must			manner	,	
	alastropically trapami	it the MDS up to 14 days of					

Event ID: FLVO11

Facility ID: NJ61904

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/18/2020 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	
		315409	B. WING			10/	08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
VALLEY V	IEW REHABILITATION A	ND HEALTHCARE CTR			SUMMIT AVENUE IEWTON, NJ 07860		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 640	Continued From page	<u>م</u>	F	640			
1 0 10	the assessment being			040	Systemic Changes		
					All discharged residents will be review	ed	
		4 PM, the surveyor reviewed nic medical record. The			during the morning report by the Interdisciplinary Team to ensure that		
		he resident was admitted to			discharge MDS are completed and		
	the facility on	vith diagnoses that included			submitted timely		
		Further review of the			Monitoring		
		he resident was discharged			A QAPI for MDS completion and	ill	
	to the community on	• •			transmission for discharged residents done by the DON/designee monthly x		
	-	d the MDS assessment			and quarterly thereafter. QAPI report v	vill	
	history which revealed Discharge MDS Asse	d that there was no ssment completed for the			be submitted to Administrator and will discussed during the quarterly meeting		
	resident's discharge o	i				5	
	2. On 10/2/19 at 1:30 Resident #2's electron record revealed that to the facility or included review of the record re expired in the facility of The surveyor reviewed history which revealed Facility tracking recor resident's death on On 10/7/19 at 1:45 Pl Administrator and the was also responsible	PM, the surveyor reviewed nic medical record. The he resident was admitted to with diagnoses that Further evealed that the resident on the MDS assessment d that there was no Death in d MDS completed for the M, the surveyor spoke to the Director of Nursing, who in completing MDS ng the above concern. They					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0.0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		SURVEY LETED
		315409	B. WING			10/	08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	00/2013
VALLEY V	IEW REHABILITATION A	ND HEALTHCARE CTR			SUMMIT AVENUE IEWTON, NJ 07860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 641 SS=D	Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on interview a determined that the fa complete the Minimu 14 residents reviewed deficient practice was On 10/2/19 at 10:00 A Resident #22 in their wheelchair. The surve who was alert and ori On 10/7/19 at 11:30 A Resident # 22's electuresident was admitted and readmitted on included but were not	ents of Assessments. at accurately reflect the is not met as evidenced and record review, it was acility failed to accurately m Data Set (MDS) for 1 of d (Resident #22). This e evidenced by the following: AM, the surveyor observed room seated in a eyor interviewed the resident ented. AM, the surveyor reviewed ronic medical record. The d to the facility on <b>accurate</b>		641		to to the tts	10/28/19
	section Resident #22 was ad On 10/7/19 at 1:45 Pl the Director of Nursin responsible in completion	, that mitted with a diagnosis of M, the surveyor interviewed g (DON), who was also eting the MDS assessment.			Interdisciplinary team will review active diagnosis on all new admissions and re-admissions during the morning repo and interdisciplinary meeting to ensure that it is reflected in the <b>MDS</b> . Monitoring	rt	
	The DON stated that history of MDS was coded inac	the resident had a past and confirmed that the curately as the was			A QAPI for MDS will done by DON/designee for all admissions and re-admissions for MDS month		

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	S FOR MEDICARE &			CONSTRUCTION		10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION		TE SURVEY MPLETED
		315409	B. WING		1	0/08/2019
NAME OF P	ROVIDER OR SUPPLIER	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY	VIEW REHABILITATION A	ND HEALTHCARE CTR		SUMMIT AVENUE IEWTON, NJ 07860		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 641	Continued From page	e 4	F 641			
	no longer an active d			x3 and quarterly thereafter. QAPI will be submitted to Administrator		
	NJAC 8:39-11.1, 11.2	2(e)(1)		be discussed during the quarterly		
F 656		Comprehensive Care Plan	F 656		mooting	11/6/19
SS=D	CFR(s): 483.21(b)(1)	1 -				
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that in objectives and timefra medical, nursing, and needs that are identif assessment. The con describe the following (i) The services that a or maintain the reside physical, mental, and required under §483. (ii) Any services that under §483.24, §483. provided due to the re under §483.10, include treatment under §483. (iii) Any specialized s rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv)In consultation wit resident's representa (A) The resident's good desired outcomes.	ames to meet a resident's mental and psychosocial ied in the comprehensive mprehensive care plan must J - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 8.10(c)(6). ervices or specialized a the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. h the resident and the tive(s)-				

Event ID: FLVO11

Facility ID: NJ61904

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		D HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		315409	B. WING		10/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
VALLEY V	IEW REHABILITATION A	ND HEALTHCARE CTR		I SUMMIT AVENUE NEWTON, NJ 07860	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 656	whether the resident's community was assess local contact agencies entities, for this purpor (C) Discharge plans in plan, as appropriate, i requirements set forth section. This REQUIREMENT by: Based on observation review, it was determindevelop a comprehen plan for residents with practice was identified (Resident #22 and # comprehensive care point the following: 1. On 10/2/19 at 10:00 observed Resident #22 wheelchair. The surveyor reviewer record. The resident wo on and readm diagnoses that include review of the progress documented that Res	a desire to return to the seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this T is not met as evidenced in, interview and record ined that the facility failed to asive, person-centered care to for 2 of 14 residents 11) reviewed for blans and was evidenced by 0 AM, the surveyor 22 in their room seated in a d Resident # 22's medical was admitted to the facility nitted on with ed but were not limited to Further	F 656	Specific Corrective Action 1.A comprehensive, person-centered plan was developed for the use of as needed for Resident #22 2.A comprehensive, person-centered plan was developed for the use of at HS for resident # 11. 3.All licensed staff were in serviced to ensure that all residents that were receiving have a comprehens person-centered care plan for the use Identification All residents have the potential to be affected by this deficient practice. All resident receiving will have care plan audit to ensure that they have a comprehensive, person centered care plan for the use of Systemic Changes The interdisciplinary team will discuss comprehensive, person centered care plan during the morning report and interdisciplinary meeting for all resident with used Monitoring	care

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	-	D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 03/18/2020 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE	
		315409	B. WING		10/	08/2019
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW REHABILITATION A	ND HEALTHCARE CTR		SUMMIT AVENUE IEWTON, NJ 07860		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	<ul> <li>2. On 10/01/19 at 9:30 observed Resident #1 wheelchair by the win There was an the resident. Resident the resident. Resident the resident. Resident to On 10/02/19 at 9:25 A Resident #11 seated if room. The behind the resident.</li> <li>The surveyor reviewer record. Resident #11 on from an acting from acting from an acting from a</li></ul>	<ul> <li>0 AM, the surveyor</li> <li>11 in their room seated in a dow reading a newspaper.</li> <li>directly behind t #11 told the surveyor that the finite morning.</li> <li>t and the nurse or CNA him/her.</li> <li>AM, the surveyor observed in a wheelchair in their was directly</li> <li>d Resident # 11's medical was admitted to the facility cute care hospital with ed but were not limited to</li> <li>wed the Licensed Practical e resident who stated that the finite only during</li> <li>d the resident's care plan. an for Resident #11's nightly</li> <li>M, the surveyor spoke to the Director of Nursing concerns. They did not</li> </ul>	F 656	A care plan QAPI for all residents receiving oxygen will done by the DON/designee monthly x3 and quarte thereafter. QAPI report will be submit to Administrator and will be discussed during the quarterly meeting	ed	
F 710	NJAC 8:39-11.2(e)(1) Resident's Care Supe		F 710			10/28/19

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	-	D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/18/2020 MAPPROVED O. 0938-0391
STATEMENT O	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		315409	B. WING			10	/08/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
VALLEY V	IEW REHABILITATION A	ND HEALTHCARE CTR			SUMMIT AVENUE IEWTON, NJ 07860		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 710 SS=D	Continued From page CFR(s): 483.30(a)(1)(		F	710			
	recommendation that a facility. Each reside care of a physician. A assistant, nurse pract specialist must provid immediate care and n §483.30(a) Physician The facility must ensu §483.30(a)(1) The me is supervised by a phy §483.30(a)(2) Anothe medical care of reside physician is unavailab This REQUIREMENT by: Based on observation review, it was determini implement Physician's administration of was identified for 2 of and #11) reviewed ar following: 1. On 10/2/19 at 10:00 observed Resident #2 wheelchair.	<ul> <li>an individual be admitted to ent must remain under the A physician, physician itioner, or clinical nurse e orders for the resident's eeds.</li> <li>Supervision.</li> <li>supervision.</li> <li>tre that-</li> <li>edical care of each resident ysician;</li> <li>r physician supervises the ents when their attending ble.</li> <li>is not met as evidenced</li> <li>h, interview and record ned that the facility failed to s Orders (PO) for the</li> <li>This deficient practice 5 residents (Resident #22 nd was evidenced by the</li> <li>D AM, the surveyor 22 in their room seated in a</li> </ul>			Specific Corrective Action 1.Resident #22- a Physician s Orduse of a sneeded was obta 2.Resident #11- a Physician s orduse of at H.S. was obtained All licensed staff were in serviced to ensure that all residents that needs therapy must have a Physic Order	ined on er for s	
	record. The resident wo	d Resident # 22's medical vas admitted to the facility nitted on with ed but were not limited to Further			Identification All residents have the potential to b affected by this deficient practice. A will be done all residents receiving		

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Facility ID: NJ61904

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDERSUPLER       (X2) AUTTRY LE CONSTRUCTION A BUILDING       (X2) OUTTRY ESURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       315409       B. WING       10008/2019         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       13008/2019         VALLEY VIEW REHABILITATION AND HEALTHCARE CTR       STREET ADDRESS, CITY, STATE, ZIP CODE       13008/07860         (Y4) ID PIFETX       SUMMARY STREMENT OF DEFICIENCIES (EXCH OPERCENT MUST EFFECTIBED BY FULL REGULATORY OF LGC DENTIFYING INFORMATION)       DPC       DPC CORRECTION (EXCH OPERCENT MUST EFFECTIBED BY FULL REGULATORY OF LGC DENTIFYING INFORMATION)       DPC       DPC CORRECTION (EXCH OPERCENT MUST EFFECTIBED BY FULL REGULATORY OF LGC DENTIFYING INFORMATION)       DPC CORRECTION (EXCH OPERCENT MUST EFFECTIBED BY FULL REGULATORY OF LGC DENTIFYING INFORMATION)       DPC CORRECTION (EXCH OPERCENT MUST EFFECTIBED BY FULL REGULATORY OF LGC DENTIFYING INFORMATION)       DPC CORRECTION (EXCH OPERCENT MUST EFFECTIBED BY FULL REGULATORY OF LGC DENTIFYING INFORMATION)       DPC CORRECTION (EXCH OPERCENT MUST EFFECTIBED BY FULL REGULATORY OF LGC DENTIFYING INFORMATION)       DEFICIENCY)       DPC CORRECTION (EXCH OPERCENT ACTION INFORMATION (EXCH OPERCENT ACTION INFORMATION)       DEFICIENCY)       DPC CORRECTION (EXCH OPERCENT ACTION INFORMATION (EXCH OPERCENT ACTION INFORMATION)       DEFICIENCY)       DPC CORRECTION (EXCH OPERCENT ACTION INFORMATION (EXCH OPERCENT ACTION INFORMATION)       DEFICIENCY)       DPC CORRECTION (EXCH OPERCENT ACTION INFORMATION)       DPC CORRECTION (EXCH OPERCENT			ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2P CODE       VALLEY VIEW REHABILITATION AND HEALTHCARE CTR     STREET ADDRESS, CITY, STATE, 2P CODE       VALLEY VIEW REHABILITATION AND HEALTHCARE CTR     ISUMMIT AVENUE       NEWTON, NJ 07860     NEWTON, NJ 07860       PREFIX     ISUMMARY STATEMENT OF DEPICIENCIES (ECAPI DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX       F 710     Continued From page 8 review of the progress notes dated and documented that Resident #22 was administered to the Registered Nurse assigned to the resident who stated that was being administered to the resident on an "as Needed" basis.     F 710       On 10/7/19 at 11:30 AM, the surveyor spoke to the Registered Nurse assigned to the resident who stated that was being administered to the resident on an "as Needed" basis.     F 710       The surveyor reviewed the September 2019 Physician Order for Must assema advance regarding the above concern who agreed that there was no physician order for mean administration.     A 010/1/19 at 1:45 PM, the Administration.       2. On 10/07/19 at 9:30 AM, the surveyor observed Resident #211 in their room seated in a wheelchair by the window reading a newspaper. There was an implysician order for the administration.     S 0n 10/07/19 at 9:30 AM, the surveyor observed Resident #11 in their room seated in a wheelchair by the window reading a mewspaper. There was an implysician order for the imply directly behind     S 0n 10/07/19 at 9:30 AM, the surveyor observed Resident #11 in their room seated in a wheelchair by the window reading a mewspaper.     S 0n 10/07/19 at 9:30 AM, the surveyor observed Resident #11 in their room seated in a wh	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       VALLEY VIEW REHABILITATION AND HEALTHCARE CTR     STREET ADDRESS, CITY, STATE, ZIP CODE       (C4, ID PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)     PROVIDER'S PLAN OF CORRECTION (EACH OCRRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OCRRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OCRRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OCRRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OCRRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OCRRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OCRRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OCRRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OF CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OF CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTION (EACH OF CORRECTVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OPROVIDER'S PLAN OF CORRECTURATION (INTERNET ADDRESS, CITY, STATE, ZIP CODE (EACH OF CORRECTURATION)     F710         The survey or reviewed that September 2019 Physician Order for Me Wis approprime and ministration. </td <td></td> <td></td> <td>315409</td> <td>B. WING</td> <td></td> <td></td> <td>10/</td> <td>08/2019</td>			315409	B. WING			10/	08/2019
NEWTON, NJ 07860         PALLEY VIEW REHABILITATION AND HEALTHCARE CTR       NEWTON, NJ 07860         PALIEY VIEW REHABILITATION AND HEALTHCARE CTR       NEWTON, NJ 07860         PALIEY VIEW REHABILITATION AND HEALTHCARE CTR       NEWTON, NJ 07860         PALIEY VIEW REHABILITATION AND HEALTHCARE CTR       NEWTON, NJ 07860         PALIEY       NEWTON, NJ 07860         PALIEY       REVIEW REHABILITATION AND HEALTHCARE CTR         PALIEY       NEWTON, NJ 07860         PALIEY       REVIEW OF DEPICIENCY         PALIEY       REVIEW OF THE APPROPRIATE         DEFICIENCY       COMPLETION         PALIEY       NEWTON, NJ 07860         PALIEY       REVIEW OF LECENCED DY PULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 710       Therapy to ensure that they have a Physician CS Order for the app use. An audit will be one on all residents using oxygen therapy by DON/designee to ensure that Physician: S Order was obtained monthy x 3 and quarterly thereafter. QAPI report will be submitted to the Administrator and the Director of Nursing was made aware regarding the above concern who agreed that there was no physician order for the administration.       On 10/01/19 at 9:30 AM, the surveyor observed Resident #111 in their room seated in a wheelchair by the window reading a newspaper. There was an implete the beind	NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED to THE APPROPRIATE DEFICIENCY)       COMPLETION DEFICIENCY)         F 710       Continued From page 8 review of the progress notes dated in and information and the Director of Nursing was made aware regarding the above concern who agreed that there was no physician order for the information.       F 710         2. On 10/01/19 at 9:30 AM, the surveyor observed Resident #11 in their room seated in a wheelchair by the window reading a newspaper. There was an information an information and the Director of Nursing was made aware regarding the above concern who agreed that there was no physician order for the information and information.       F 710         2. On 10/01/19 at 9:30 AM, the surveyor observed Resident #11 in their room seated in a wheelchair by the window reading a newspaper. There was an information in a maximum information informatio	VALLEY V	IEW REHABILITATION A	ND HEALTHCARE CTR					
review of the progress notes dated	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
the resident. The resident told the surveyor that he/she does not use the during the day, only at night and the nurse or aides apply the On 10/02/19 at 9:25 AM, the surveyor observed Resident #11 in r room seated in r wheelchair with the behind The surveyor reviewed Resident # 11's medical record. Resident #11 was admitted to the facility	F 710	review of the progress documented that Ress on 10/7/19 at 11:30 A the Registered Nurse who stated that to the resident on an The surveyor reviewe Physician Order Shee was no physician order to Resident #22. On 10/7/19 at 1:45 Pf Director of Nursing wa the above concern wh physician order for the 2. On 10/01/19 at 9:3 observed Resident #7 wheelchair by the win There was an the resident. The ress he/she does not use to only at night and the for On 10/02/19 at 9:25 A Resident #11 in r row wheelchair with the	AM, the surveyor spoke to assigned to the resident was being administered "as Needed" basis. Ad the September 2019 et which revealed that there er for administration AM, the Administrator and the as made aware regarding no agreed that there was no e administration. AM, the surveyor administration. AM, the surveyor administration.	F	710	Physician s Order for therapy use. An audit will be performed by eac unit nurse. Monitoring A QAPI will be done on all residents us oxygen therapy by DON/designee to ensure that a Physician order was obtained monthly x 3 and quarterly thereafter. QAPI report will be submitted to the Administrator and will be discussed	:h :ing :d	

If continuation sheet Page 9 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       315409       B. WING       10/08/2019         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 1 SUMMIT AVENUE NEWTON, NJ 07860       10/08/2019         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION       (X5)		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       VALLEY VIEW REHABILITATION AND HEALTHCARE CTR     STREET ADDRESS, CITY, STATE, ZIP CODE       (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) COMPLETM DATE       F 710     Continued From page 9 on from an acute care hospital with diagnoses that included but were not limited to interview of Resident #11's medical record revealed the following documentation; Progress Note dated from 11:23 PM written by a Registered Nurse (RN) documented     F 710	STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         VALLEY VIEW REHABILITATION AND HEALTHCARE CTR       ISUMMARY STATEMENT OF DEFICIENCIES       ISUMMARY STATEMENT OF DEFICIENCIES         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETN TAG       COMPLETN (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY)         F 710       Continued From page 9 on from an acute care hospital with diagnoses that included but were not limited to       F 710         Further review of Resident #11's medical record revealed the following documentation; Progress Note dated time 11:23 PM written by a Registered Nurse (RN) documented       F 710			315409	B. WING			10/	08/2019
VALLEY VIEW REHABILITATION AND HEALTHCARE CTR       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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETM (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETM DATE         F 710       Continued From page 9 on from an acute care hospital with diagnoses that included but were not limited to Further review of Resident #11's medical record revealed the following documentation; Progress Note dated function timed 11:23 PM written by a Registered Nurse (RN) documented       F 710	NAME OF P	ROVIDER OR SUPPLIER					·	
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLETM DATE         F 710       Continued From page 9 on from an acute care hospital with diagnoses that included but were not limited to F 710       F 710       F 710         Further review of Resident #11's medical record revealed the following documentation; Progress Note dated timed 11:23 PM written by a Registered Nurse (RN) documented       F 710       F 710	VALLEY V	IEW REHABILITATION A	ND HEALTHCARE CTR					
on from an acute care hospital with diagnoses that included but were not limited to Further review of Resident #11's medical record revealed the following documentation; Progress Note dated timed 11:23 PM written by a Registered Nurse (RN) documented	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
A Physician progress note dated timed 4:49 PM documented that resident has A Physician progress note dated	F 710	on from an ac diagnoses that includ Further review of Res revealed the following Note dated Registered Nurse (RN 	cute care hospital with ed but were not limited to	F	710			

If continuation sheet Page 10 of 10

## PRINTED: 03/18/2020 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		(X3) DATE SURVEY COMPLETED
		061904	B. WING		10/08/2019
	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT IT AVENUE N, NJ 07860	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
S 000	Initial Comments		S 000		
	ADMINISTRATIVE C STANDARDS FOR L TERM CARE FACILI SUBMIT A PLAN OF INCLUDING A COMP DEFICIENCY AND E IMPLEMENTED. FA DEFICIENCIES MAY ENFORCEMENT AC WITH THE PROVISI	PLETION DATE, FOR EACH NSURE THAT THE PLAN IS ILURE TO CORRECT RESULT IN TION IN ACCORDANCE ONS OF THE NEW RATIVE CODE, TITLE 8, FORCEMENT OF			
S2905	8:39-43.1(a)(2) Certi	fication of Nurse Aides	S2905		10/28/19
	criteria shall be consi be competent to work licensed long-term ca 2. Has been em and is currently enrol aide in long term and scheduled to cor evaluation program	meets any of the following idered by the Department to as a nurse aide in a are facility in New Jersey: bloyed for less than 120 days led in an approved nurse care facilities training course nplete the competency n (skills and written/oral 20 days of employment; or			
	by: Based on interview a determined that the f	「 is not met as evidenced nd record review, it was acility failed to follow New nents in the hiring of 1 of 4 rom <b>ute th</b> rough		Specific Corrective Action The Nurse s Aide (Nursing Student) terminated as of for failure to submit the Certified Nurses Aide certification.	

10/30/19

STATE FORM

Electronically Signed

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If continuation sheet 1 of 2

## PRINTED: 03/18/2020 FORM APPROVED

STATEMEN	ey Department of Hea FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		061904	B. WING		10/08/2019	
	ROVIDER OR SUPPLIER	AND HEALTHCARE (	DDRESS, CITY, ST, IT AVENUE N, NJ 07860	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLE	
S2905	The Surveyor review for 5 new employees which includ (CNAs), 1 Licensed F Nurse's Aide/Student background checks, for the LPN, and Cer Aides. It also include timely History and Ph testing for Tuberculos order except for 1 of One Nurses' Aide (St The student was enro and had completed th Nursing Course. Doc included the transcrip successful completio above. However, the Department's written, certification and was to work in a Nurse-Ai	ed the New Employee Files hired from 6/4/19 through led 3 Certified Nurses' Aides Practical Nurse (LPN), and 1 t Nurse. This review included reference checks, License tifications for the Nurses' d Medical Record review for nysicals as well as Mantoux sis. The records were all in the Nurses' Aides. tudent) was hired on to the Nurses'. olled in a Nursing program he required Fundamentals in cumentation in the file ot, which indicated the n of the course mentioned Student had not taken the /oral examination for not permitted by regulation	S2905	HR was in-serviced on the New Jers State requirements and criteria to be considered by the Department of He be competent to work as a nurse aid licensed long-term care facility in Ne Jersey. Identification HR will verify certification on all can of employment that meets the criteri the Department of Health to be com to work as a nurse aide in a licensed long-term care facility in New Jersey Systemic Changes HR will only offer employment as a r aide to candidates that have a valid Aide certification or meet the criter from the State of New Jersey as a competent candidate to work as a N Aide. Monitoring QAPI will be done on all new hire Nt Aide to ensure that they have a va and current certification or meet the criteria of New Jersey State Departr Health to be competent to work as a aide in a licensed long-term care fac	e ealth to de in a ew didates ia by petent d , nurse Nurse ia lurse alid ment of a nurse	

FLVO11