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

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 ______	10/08/2019

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 000	INITIAL COMMENTS Standard Survey: 10/8/19 Census: 22 Sample Size: 16	F 000		
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640		10/28/19

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

Electronically 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.

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F 640	Continued From page 1 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 2 of 14 residents reviewed for resident assessment (Resident #1, #2). This deficient practice was evidenced by the following: On 10/2/19 at 1:14 PM, the surveyor conducted the survey's Facility Assessment Task which includes review of designated residents' MDS Assessments. The MDS is a comprehensive tool that is federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS up to 14 days of	F 640	Corrective Action 1.Resident #1 Discharged MDS was completed and transmitted on [redacted] 2.Resident #2 Discharged MDS was completed and transmitted on [redacted] Interdisciplinary Team were re-educated with regards to timely completion and submission of the MDS in accordance with the federal guidelines. Identification All residents have the potential to be affected by this deficient practice. MDS audit will be done on all discharge residents to ensure that discharged MDS are completed and transmitted on a timely manner	

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F 640	Continued From page 2 the assessment being completed. 1.) On 10/2/19 at 1:14 PM, the surveyor reviewed Resident #1's electronic medical record. The record revealed that the resident was admitted to the facility on [redacted] with diagnoses that included [redacted] Further review of the record revealed that the resident was discharged to the community on [redacted]. The surveyor reviewed the MDS assessment history which revealed that there was no Discharge MDS Assessment completed for the resident's discharge date of [redacted] 2. On 10/2/19 at 1:30 PM, the surveyor reviewed Resident #2's electronic medical record. The record revealed that the resident was admitted to the facility on [redacted] with diagnoses that included [redacted] Further review of the record revealed that the resident expired in the facility on [redacted] The surveyor reviewed the MDS assessment history which revealed that there was no Death in Facility tracking record MDS completed for the resident's death on [redacted] On 10/7/19 at 1:45 PM, the surveyor spoke to the Administrator and the Director of Nursing, who was also responsible in completing MDS assessments, regarding the above concern. They did not provide any further information. NJAC 8:39-11.2	F 640	Systemic Changes All discharged residents will be reviewed during the morning report by the Interdisciplinary Team to ensure that discharge MDS are completed and submitted timely Monitoring A QAPI for MDS completion and transmission for discharged residents will done by the DON/designee monthly x3 and quarterly thereafter. QAPI report will be submitted to Administrator and will be discussed during the quarterly meeting	

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for 1 of 14 residents reviewed (Resident #22). This deficient practice was evidenced by the following: On 10/2/19 at 10:00 AM, the surveyor observed Resident #22 in their room seated in a wheelchair. The surveyor interviewed the resident who was alert and oriented. On 10/7/19 at 11:30 AM, the surveyor reviewed Resident # 22's electronic medical record. The resident was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that included but were not limited to [redacted] [redacted] of the resident's MDS, an assessment tool used to facilitate the management of care, dated [redacted] documented under [redacted] (the section [redacted], that Resident #22 was admitted with a diagnosis of [redacted]. On 10/7/19 at 1:45 PM, the surveyor interviewed the Director of Nursing (DON), who was also responsible in completing the MDS assessment. The DON stated that the resident had a past history of [redacted] and confirmed that the MDS was coded inaccurately as [redacted] was	F 641	Specific Corrective Plan of Action Resident #22 a Modification of Admission - 5 Day MDS was completed and transmitted for the correction of [redacted] removing the Dx [redacted] an active diagnosis Interdisciplinary Team were in serviced to review [redacted] the MDS to ensure the accuracy of [redacted] of the MDS reflects the active diagnosis at the time of admission and re-admission Identification All residents have the potential to be affected by this deficient practice. Interdisciplinary Team were re-educated with regards to accuracy [redacted] of the MDS that should reflect the current resident status Systemic Changes Interdisciplinary team will review active diagnosis on all new admissions and re-admissions during the morning report and interdisciplinary meeting to ensure that it is reflected in the [redacted] of the MDS. Monitoring A QAPI for MDS [redacted] will done by the DON/designee for all admissions and re-admissions for MDS [redacted] monthly	10/28/19

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F 641	Continued From page 4 no longer an active diagnosis. NJAC 8:39-11.1, 11.2(e)(1)	F 641	x3 and quarterly thereafter. QAPI report will be submitted to Administrator and will be discussed during the quarterly meeting	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document	F 656		11/6/19

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F 656	Continued From page 5 whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to develop a comprehensive, person-centered care plan for residents with [redacted] use. This deficient practice was identified for 2 of 14 residents (Resident #22 and #11) reviewed for comprehensive care plans and was evidenced by the following: 1. On 10/2/19 at 10:00 AM, the surveyor observed Resident #22 in their room seated in a wheelchair. The surveyor reviewed Resident # 22's medical record. The resident was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that included but were not limited to [redacted] Further review of the progress notes dated [redacted], [redacted] and [redacted] documented that Resident #22 was receiving [redacted]. The surveyor reviewed the resident's care plan which did not reflect a care plan for the use of [redacted]	F 656	Specific Corrective Action 1.A comprehensive, person-centered care plan was developed for the use of [redacted] as needed for Resident #22 2.A comprehensive, person-centered care plan was developed for the use of [redacted] at HS for resident # 11. 3.All licensed staff were in serviced to ensure that all residents that were receiving [redacted] have a comprehensive, person-centered care plan for the use of [redacted] Identification All residents have the potential to be affected by this deficient practice. All resident receiving [redacted] will have care plan audit to ensure that they have a comprehensive, person centered care plan for the use of [redacted] Systemic Changes The interdisciplinary team will discuss the comprehensive, person centered care plan during the morning report and interdisciplinary meeting for all residents with [redacted] used Monitoring	

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F 656	Continued From page 6 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 [redacted] directly behind the resident. Resident #11 told the surveyor that he/she does not use the [redacted] in the morning. It is used only at night and the nurse or CNA applies the [redacted] to him/her. On 10/02/19 at 9:25 AM, the surveyor observed Resident #11 seated in a wheelchair in their room. The [redacted] was directly behind the resident. The surveyor reviewed Resident # 11's medical record. Resident #11 was admitted to the facility on [redacted] from an acute care hospital with diagnoses that included but were not limited to [redacted]. The surveyor interviewed the Licensed Practical Nurse assigned to the resident who stated that the resident receives the [redacted] only during bedtime. The surveyor reviewed the resident's care plan. There was no care plan for Resident #11's nightly use of [redacted]. On 10/7/19 at 1:45 PM, the surveyor spoke to the Administrator and the Director of Nursing regarding the above concerns. They did not provide any further information. NJAC 8:39-11.2(e)(1)(2)	F 656	A care plan QAPI for all residents receiving oxygen will done by the DON/designee monthly x3 and quarterly thereafter. QAPI report will be submitted to Administrator and will be discussed during the quarterly meeting	
F 710	Resident's Care Supervised by a Physician	F 710		10/28/19

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F 710 SS=D	Continued From page 7 CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to implement Physician's Orders (PO) for the administration of [redacted]. This deficient practice was identified for 2 of 5 residents (Resident #22 and #11) reviewed and was evidenced by the following: 1. On 10/2/19 at 10:00 AM, the surveyor observed Resident #22 in their room seated in a wheelchair. The surveyor reviewed Resident # 22's medical record. The resident was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses that included but were not limited to [redacted]. Further	F 710	Specific Corrective Action 1.Resident #22- a Physician□s Order for use of [redacted] as needed was obtained on [redacted] 2.Resident #11- a Physician□s order for use of [redacted] at H.S. was obtained All licensed staff were in serviced to ensure that all residents that needs [redacted] therapy must have a Physician□s Order Identification All residents have the potential to be affected by this deficient practice. An audit will be done all residents receiving [redacted]	

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F 710	Continued From page 8 review of the progress notes dated [redacted], [redacted] and [redacted] documented that Resident #22 was administered [redacted] On 10/7/19 at 11:30 AM, the surveyor spoke to the Registered Nurse assigned to the resident who stated that [redacted] was being administered to the resident on an "as Needed" basis. The surveyor reviewed the September 2019 Physician Order Sheet which revealed that there was no physician order for [redacted] administration to Resident #22. On 10/7/19 at 1:45 PM, the Administrator and the Director of Nursing was made aware regarding the above concern who agreed that there was no physician order for the [redacted] administration. 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 [redacted] directly behind the resident. The resident told the surveyor that he/she does not use the [redacted] during the day, only at night and the nurse or aides apply the [redacted]. On 10/02/19 at 9:25 AM, the surveyor observed Resident #11 in [redacted]r room seated in [redacted]r wheelchair with the [redacted] behind [redacted]. The surveyor reviewed Resident # 11's medical record. Resident #11 was admitted to the facility	F 710	therapy to ensure that they have a Physician□s Order for [redacted] therapy use. An audit will be performed by each unit nurse. Monitoring A QAPI will be done on all residents using oxygen therapy by DON/designee to ensure that a Physician□s Order was obtained monthly x 3 and quarterly thereafter. QAPI report will be submitted to the Administrator and will be discussed during the quarterly meeting.	

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F 710	Continued From page 9	F 710		

on [redacted] from an acute care hospital with diagnoses that included but were not limited to [redacted].

Further review of Resident #11's medical record revealed the following documentation; Progress Note dated [redacted] timed 11:23 PM written by a Registered Nurse (RN) documented [redacted]." A Progress Note dated [redacted] timed 2:33 AM documented [redacted]

A Physician progress note dated [redacted] timed 4:49 PM documented that resident has '[redacted]." A Physician progress note dated [redacted] timed 5:14 PM documented [redacted]

The surveyor interviewed the Licensed Practical Nurse who was assigned to the resident on 10/07/19 at 10:38 AM. The LPN stated that the resident receives the [redacted] only during the evening hours.

The surveyor reviewed the September 2019 and October 2019 Physician Order Sheet which revealed that there was no Physician Order for [redacted] administration to Resident #11.

On 10/7/19 at 1:45 PM, the Administrator and the Director of Nursing was made aware of the above concern. Both confirmed there was no physician order for the [redacted] administration.

NJAC 8:39-27.1 (b)

New Jersey Department of Health

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	061904	A. BUILDING: ______ B. WING ______	10/08/2019

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S2905	8:39-43.1(a)(2) Certification of Nurse Aides (a) An individual who meets any of the following criteria shall be considered by the Department to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey: 2. Has been employed for less than 120 days and is currently enrolled in an approved nurse aide in long term care facilities training course and scheduled to complete the competency evaluation program (skills and written/oral examination) within 120 days of employment; or This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to follow New Jersey State requirements in the hiring of 1 of 4 Nurses' Aides hired from [redacted] through [redacted]	S2905	Specific Corrective Action The Nurse�s Aide (Nursing Student) was terminated as of [redacted] for failure to submit the Certified Nurses� Aide certification.	10/28/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 10/30/19

New Jersey Department of Health

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S2905	Continued From page 1 The Surveyor reviewed the New Employee Files for 5 new employees hired from 6/4/19 through [redacted] which included 3 Certified Nurses' Aides (CNAs), 1 Licensed Practical Nurse (LPN), and 1 Nurse's Aide/Student Nurse. This review included background checks, reference checks, License for the LPN, and Certifications for the Nurses' Aides. It also included Medical Record review for timely History and Physicals as well as Mantoux testing for Tuberculosis. The records were all in order except for 1 of the Nurses' Aides. One Nurses' Aide (Student) was hired on [redacted]. The student was enrolled in a Nursing program and had completed the required Fundamentals in Nursing Course. Documentation in the file included the transcript, which indicated the successful completion of the course mentioned above. However, the Student had not taken the Department's written/oral examination for certification and was not permitted by regulation to work in a Nurse-Aide (NA) capacity. The facility stated that the aide was employed from [redacted] to [redacted].	S2905	HR was in-serviced on the New Jersey State requirements and criteria to be considered by the Department of Health to be competent to work as a nurse aide in a licensed long-term care facility in New Jersey. Identification HR will verify certification on all candidates of employment that meets the criteria by the Department of Health to be competent 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 nurse aide to candidates that have a valid Nurse Aide certification or meet the criteria from the State of New Jersey as a competent candidate to work as a Nurse Aide. Monitoring QAPI will be done on all new hire Nurse Aide to ensure that they have a valid and current certification or meet the criteria of New Jersey State Department of Health to be competent to work as a nurse aide in a licensed long-term care facility	