STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	**544 TEANECK ROAD** **TEANECK, NJ 07666**

(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 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 and interview on 02/28/2024 in the presence of facility management, it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101:2012 Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 87 residents of the facility and was evidenced by the following: At 9:15 AM in the presence of the facility's Maintenance Director (MD) and Regional Plant Operations Director (RPOD), the surveyor observed that the roof overhang at the	K 351	2/28/24 the Environmental Director contacted Johnson Control and City Fire (vendors) for quotes for installation of an automatic fire sprinkler. No residents were adversely affected by this practice All residents residing in the facility have the potential to be affected by this practice. Sprinkler head will be installed in the delivery/receiving area as required. The Director of Maintenance (or	4/30/24

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

Electronically Signed | 03/22/2024

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 351	Continued From page 1 delivery/receiving area was not provided with automatic fire sprinkler protection. The overhang measured 12-feet by 7-feet, was constructed with combustible materials and was attached to the building. In an interview at the time of observation, the MD and RPOD confirmed the findings. The facility's Administrator was notified of the deficient practice during the Life Safety Code survey exit conference at 2:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	designee) will monitor the delivery area daily to ensure it remains free of combustible items until the sprinkler head is installed. The Director of Maintenance will report findings of these audits weekly to the Administrator, until sprinkler is installed.	
K 353 SS=F	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	K 353		4/30/24

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	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

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K 353	Continued From page 2 by: Based on observation, interview, and documentation review on 02/27/2024, it was determined that the facility failed to inspect and test facility's private fire hydrant in accordance with NFPA 25 and NFPA 101:2012 Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 87 residents of the facility and was evidenced by the following: During documentation review, the facility failed to provide any record on inspection and testing for facility's private hydrant. At 12:00 PM, an interview was conducted with the Maintenance Director and the Regional Plant Operations Director. The RPOD stated that there were discrepancies between water vender and sprinkler service, so inspection and testing was not conducted. The Administrator was notified of the deficient practice at 2:45 PM during the Life Safety Code exit conference on 02/28/2024. NJAC 8:39-31.2 NFPA 25	K 353	The vendor, City Fire was contacted by the Environmental Director on 2/27/24 to inspect the facility□s private fire hydrant. (see attached service inspection report). No residents were negatively affected by this practice. All residents residing in the facility have the potential to be affected by this practice. On 1/28/24 the vendor, City Fire conducted a service visit to the facility to inspect the facility□s fire hydrant. The fire hydrant passed it□s yearly inspection. Fire hydrant will be inspected yearly. The Director of Maintenance (or designee) will ensure annual inspections are completed for the facility□s private fire hydrant. The Director of Maintenance will report findings to the Adminstrator and QAPI on an annual basis.	
K 524 SS=D	HVAC - Direct-Vent Gas Fireplaces CFR(s): NFPA 101 Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	K 524		4/30/24

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	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

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K 524	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/28/2024 in the presence of facility management, it was determined that the facility failed to provide (1) a protective wire mesh or screen on a Direct-Vent Gas Fireplace and (2) electrically supervised carbon monoxide detection in accordance with NFPA 54 and NFPA 101:2012 Sections 9.8, 19.5.2.3. (2)d 19.5.2.3. (2)f. This deficient practice had the potential to affect all 87 residents of the facility and was evidenced by the following: At 11:28 AM, the surveyor observed a Direct-Vent Gas fireplace with no protective wire mesh or screen located in the 1st floor main dining room. At approximately 11:30 AM the surveyor observed that the Direct-Vent gas fireplace was provided with a battery operated carbon monoxide detector, not the required hard wired carbon monoxide detector interconnected to the fire alarm system. In an interview at the time of observations, the Maintenance Director confirmed the findings. The facility's Administrator was notified of the deficient practice during the Life Safety Code survey exit conference at 2:45 PM. NJAC 8:39-31.2 (e) NFPA 54	K 524	The fireplace in the main dining area was immediately taken out of service. No residents were adversely affected. All residents have the potential to be affected by this practice. The fireplace was immediately taken out of service. The following vendors: Johnson Control, City Fire and Scotch Hills were all contacted by the Environmental Director on 2/29/24 for quotes for installation of a custom screen /protective mesh for the Direct-Vent fireplace, as well as for the placement of a hard-wired carbon monoxide detector. The Director of Maintenance (or designee) will monitor the fireplace daily to ensure it remains out of service until the custom screen and carbon monoxide detector are installed. Findings will be reported quarterly to the Administrator and present at QAPI Meetings.	

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K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced	K 923		4/30/24

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K 923	Continued From page 5 by: Based on observation on 02/28/2024 in the presence of the facility Maintenance Director (MD) and Regional Plant Operations Director (RPOD), it was determined that the facility failed to transport a cylinder of compressed oxygen in a manner that would protect it against tipping, and rupture in accordance with NFPA 99 and NFPA 101:2012 Sections 8.7. This deficient practice was identified for 1 of 1 compressed portable cylinder observed and was evidenced by the following: At 10:06 AM on the first-floor hallway near the laundry, the surveyor observed a Certified Nursing Assistant (CNA) transporting a portable compressed oxygen cylinder. The cylinder was not contained in a caddy or secured in a way from tipping, rupture, and damage. An interview was conducted with the MD during the time of observation, and he stated that "portable oxygen bottles should not be transported in that manner". The facility's Administrator was notified of the deficient practice at the Life Safety Code survey exit conference at 2:45 PM. NJAC 8:39-31.2 (e) NFPA 99	K 923	The Certified Nursing Assistant was immediately educated by the Director of Nursing on the proper way to transport oxygen cylinders within the facility. No residents were adversely affected by this practice All residents residing in the facility have the potential to be affected by this practice. The Director of Nursing (and designee) provided Inservice education provided to all staff for proper handling of Oxygen containers while transporting. The Director of Maintenance (or designee) will monitor staff transporting oxygen cylinders daily x 7 days, weekly x 4 weeks, monthly x 3 months. With results to the Administrator and QAPI x 3 months.	

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
315502 Y1	A. Building 01 - CARE ONE AT TEANECK B. Wing Y2	5/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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	K0351	04/30/2024	LSC	K0353	04/30/2024	LSC	K0524	04/30/2024
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0923	04/30/2024	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		
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	
2/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO