STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	301 UNION STREET HACKENSACK, NJ 07601

(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 Survey Date: 8/3/22 Census: 94 Sample: 22+3+3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Dates on site included 7/19/22, 7/18/22, 7/20/22, 7/21/22, 7/22/22, 7/25/22, 7/26/22, 7/27/22, 7/28/22, 8/2/22, and 8/3/22. Deficiencies were cited for this survey.	F 000		
F 559 SS=E	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a.) notify in writing of residents' room changes for Ex Order 26. 4B1 impaired residents and b.) develop	F 559	F559(E) How the corrective action will be accomplished for those residents found to	8/26/22

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

Electronically Signed | 08/25/2022

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F 559	Continued From page 1 facility policy for room changes in accordance with federal and state regulations. 1. On 7/22/22 at 11:07 AM, the surveyor observed Resident #55 sitting in their Ex Order 26. 4B1 in the hallway outside of their room on the second-floor nursing unit. The resident was unable to be interviewed at this time. On 7/25/22 at 11:18 AM, the surveyor interviewed Certified Nursing Aide (CNA #1) who stated the resident use to reside on the third-floor nursing unit and was moved at some point to the second-floor nursing unit. The surveyor reviewed the medical record for Resident #55. A review of the Admission Record face sheet reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 6/17/22, reflected a brief interview for mental status (BIMS) score of Ex Order 26. 4B1, which indicated Ex Order 26. 4B1 [redacted]. A review of the electronic medical record revealed no information as to when or why the resident's room was changed. On 7/26/22 at 12:54 PM, the surveyor interviewed	F 559	have been affected by the deficient practice. Resident #55, #28, and #12, and responsible parties were notified that they had a room change. No residents were negatively affected. How the facility will identify other residents having the potential to be affected by the same deficient practice. Resident #55,#28,and #12 were negatively impacted. All other residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The facility will put in place notification of room change forms to ensure that all resident and family are informed of potential room changes. The staff were in-serviced on room change forms and procedures. The facility will notify the resident and or responsible party about room change. Respect resident's rights to refuse room change and offer an appeal. How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. DON or designee will conduct audit of room change documentation weekly for 1 month then monthly for 3 months and quarterly x 3 months to monitor for completion with residents room change documentation , notification , and the opportunity to appeal a room change. DON or designee will report findings of	

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F 559	Continued From page 2 the Director of Social Services (DSS) who stated if a resident requested a room change, the request would go through the Admission Department who handled all room changes. The DSS stated room changes were documented in the electronic medical record in a Social Service Note if the social worker initiated a room change and in a Nurse Note if the nurse initiated a room change. The DSS stated the facility would speak to the resident or responsible party, but the facility did not have a form that the resident or responsible party signed agreeing to the room change. On 7/27/22 at 10:05 AM, the surveyor interviewed the second-floor nursing unit Licensed Practical Nurse/Unit Manager (LPN/UM) who stated Resident #55 was Ex Order 26. 4B1 to this floor from the third-floor nursing unit. The LPN/UM stated she was unsure the exact date the resident moved or why the resident was Ex Order 26. 4B1, that the Admissions Department verbally informed the Unit Manager a resident was moving to their floor and then the Unit Manager informed the social worker of the room change. The LPN/UM stated that there was no formal form for a room change and the social worker documented the room change in the resident's medical record. On 7/27/22 at 10:23 AM, the surveyor interviewed CNA #2 who stated Resident #55 can sometimes be Ex Order 26. 4B1 and did not want to be NJ Exec. Order 26:4.b:1 and made NJ Exec. Order 26:4.b:1 Ex Order 26. 4B1. CNA #2 stated that the resident cannot Ex Order 26. 4B1 but can understand. CNA #2 stated Resident #55 used to reside on the third-floor nursing unit but was moved to the second-floor nursing unit to room NJ Exec. Ord and then at some point was moved to room NJ Exec. Or. CNA #2 could not speak to why the resident was moved	F 559	audit to the Administrator and Quality Assurance Committee quarterly.	

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F 559	Continued From page 3 or when the resident was moved. On 7/27/22 at 11:01 AM, the surveyor interviewed the Director of Admissions who stated the process for a room change depended on if the resident or resident's representative was requesting a room change and if the facility had an available room. If the resident needed to be moved for a COVID-19 isolation status, the facility notified the resident or their representative for consent prior to moving the resident. The Director of Admissions stated when a resident was moved, the room number was changed in their electronic medical record. The Director of Admissions stated that he sent an email to staff regarding the room change, but he did not document in the electronic medical record the reason why the room was changed or who was notified. The Director of Admissions stated either the nurse or the social worker might document the room change in the medical record. On 7/27/22 at 1:24 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON). The surveyor requested documentation for Resident #55's room changes. On 7/28/22 at 10:51 AM, the DON in the presence of the LNHA, ADON, and survey team provided the surveyor with Resident #55's room changes as follows: The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 and was Ex Order 26. 4B1 to Ex Order 26. 4B1 on Ex Order 26. 4B1 for Ex Order 26. 4B1 room needs and Emergency Contact #1 was notified. The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1	F 559		

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F 559	Continued From page 4 until Ex Order 26. 4B1 and was Ex Order 26. 4B1 to Ex Order 26. 4B1 on Ex Order 26. 4B1 for renovations and resident's Guardian was made aware. The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 until Ex Order 26. 4B1 and was Ex Order 26. 4B1 to Ex Order 26. 4B1 on Ex Order 26. 4B1 for Ex Order 26. 4B1 and the resident's Guardian was made aware. At this time, the DON stated there was no documentation in the resident's medical chart for these room changes but everyone was made aware of the room changes. The DON stated that the facility did not provide residents or their representatives in writing notice of room changes. 2. On 7/25/22 at 11:16 AM, the surveyor observed Resident #28 in the second-floor nursing unit hallway self Ex Order 26. 4B1 in their Ex Order 26. 4B1. The surveyor attempted to interview the resident who did not respond. On 7/26/22 at 12:54 PM, the surveyor interviewed the DSS who stated if a resident requested a room change, the request would go through the Admission Department who handled all room changes. The DSS stated room changes were documented in the electronic medical record in a Social Service Note if the social worker initiated a room change and in a Nurse Note if the nurse initiated a room change. The DSS stated the facility would speak to the resident or responsible party, but the facility did not have a form that the resident or responsible party signed agreeing to the room change. On 7/27/22 at 10:31 AM, the surveyor interviewed CNA #2 who stated the resident was Ex Order 26. 4B1 to the second-floor nursing unit from the third-floor nursing unit. CNA #2 stated the	F 559		

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resident was NJ Exec. Order 26:4.b.1.

On 7/27/22 at 10:32 AM, the second floor Unit Clerk overheard CNA #2 inform the surveyor Resident #28 was Ex Order 26. 4B1 to the second-floor nursing unit. The Unit Clerk at this time informed the surveyor that long term care residents were all being moved from the third floor to the second-floor nursing unit.

The surveyor reviewed the medical record for Resident #28.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted].

A review of the most recent annual MDS dated 5/20/22, reflected a BIMS score of Ex Order 26. 4B1, which indicated a Ex Order 26. 4B1 [redacted].

A review of the medical record did not include when and why the resident was Ex Order 26. 4B1.

On 7/27/22 at 11:01 AM, the surveyor interviewed the Director of Admissions who stated the process for a room change depended on if the resident or resident representative was requesting a room change and if the facility had an available room. If the resident needed to be moved for a Ex Order 26. 4B1 status, the facility notified the resident or their representative for consent prior to moving the resident. The Director of Admissions stated when the resident

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was moved, the room number was changed in their electronic medical record. The Director of Admissions stated that he sent an email to staff regarding the room change, but he did not document in the electronic medical record the reason why the room was changed or who was notified. The Director of Admissions stated that either the nurse or the Social Worker might document the room change in the medical record.

On 7/27/22 at 1:24 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON). The surveyor requested documentation for Resident #28's room changes.

On 7/28/22 at 10:51 AM, the DON in the presence of the LNHA, ADON, and survey team provided the surveyor with Resident #28's room changes as follows:

The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 through Ex Order 26. 4B1, and was Ex Order 26. 4B1 to Ex Order 26. 4B1 on Ex Order 26. 4B1 for a compatible change and the resident's Power of Attorney (POA) was notified. The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 through Ex Order 26. 4B1, and was Ex Order 26. 4B1 to Ex Order 26. 4B1 on Ex Order 26. 4B1 for Ex Order 26. 4B1 rooms and the POA was notified.

At this time, the DON stated that there was no documentation in the resident's medical chart for these room changes but everyone was made aware of the room changes. The DON stated that the facility did not provide residents or their representatives in writing notice of room changes.

3. On 7/22/22 at 8:29 AM, the surveyor observed

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Resident #12 in their room on the second-floor nursing unit. The resident was sitting in their Ex Order 26. 4B1 eating breakfast. The surveyor observed the LPN administer the resident's morning medications. The resident was unable to be interviewed.

On 7/26/22 at 12:54 PM, the surveyor interviewed the DSS who stated if a resident requested a room change, the request would go through the Admission Department who handled all room changes. The DSS stated room changes were documented in the electronic medical record in a Social Service Note if the social worker initiated a room change and in a Nurse Note if the nurse initiated a room change. The DSS stated that the facility would speak to the resident or responsible party, but the facility did not have a form that the resident or responsible party signed agreeing to the room change.

On 7/27/22 at 10:32 AM, the second floor Unit Clerk stated the resident was Ex Order 26. 4B1 to this unit from the third-floor nursing unit . The Unit Clerk stated that she thought the Ex Order 26. 4B1 occurred because all the long-term care residents were going to reside on the second-floor nursing unit.

On 7/27/22 at 10:33 AM, the surveyor interviewed CNA #2 who stated the resident was pleasantly NJ Exec. Order 26 4.b.1

The surveyor reviewed the medical record for Resident #12.

A review of the Admission Record face sheet reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which

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included *Ex Order 26. 4B1* [redacted]

A review of the most recent quarterly MDS dated 7/15/22, reflected a BIMS score of *Ex Order 26. 4B1*, which indicated a *Ex Order 26. 4B1* [redacted].

On 7/27/22 at 11:01 AM, the surveyor interviewed the Director of Admissions who stated the process for a room change depended on if the resident or resident representative was requesting a room change and if the facility had an available room. If the resident needed to be moved for a *Ex Order 26. 4B1* [redacted] status, the facility notified the resident or their representative for consent prior to moving the resident. The Director of Admissions stated when a resident was moved, the room number was changed in their electronic medical record. The Director of Admissions stated he sent an email to staff regarding the room change, but he did not document in the electronic medical record the reason why the room was changed or who was notified. The Director of Admissions stated that either the nurse or the Social Worker might document the room change in the medical record.

On 7/27/22 at 1:24 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Assistant Director of Nursing (ADON). The surveyor requested documentation for Resident #12's room changes.

On 7/28/22 at 10:51 AM, the DON in the presence of the LNHA, ADON, and survey team provided the surveyor with Resident #12's room

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changes as follows:

The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 to Ex Order 26. 4B1, and was Ex Order 26. 4B1 on Ex Order 26. 4B1 to Ex Order 26. 4B1 for incompatible roommates and the resident was notified of the Ex Order 26. 4B1.
The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 to Ex Order 26. 4B1, and was Ex Order 26. 4B1 on Ex Order 26. 4B1 to Ex Order 26. 4B1 for *Ex Order 26. 4B1* rooms and the resident was notified.
The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 to Ex Order 26. 4B1, and was Ex Order 26. 4B1 on Ex Order 26. 4B1 to Ex Order 26. 4B1 for *Ex Order 26. 4B1* reasons and the resident was notified.
The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 to Ex Order 26. 4B1, and was Ex Order 26. 4B1 to Ex Order 26. 4B1 for incompatible roommates and a temporary Guardian was notified.
The resident resided in Ex Order 26. 4B1 from Ex Order 26. 4B1 to Ex Order 26. 4B1, and was Ex Order 26. 4B1 to Ex Order 26. 4B1 for *Ex Order 26. 4B1* rooms and the temporary Guardian was notified.

At this time, the DON stated there was no documentation in the resident's medical chart for these room changes but everyone was made aware of the room changes. The DON stated the facility did not provide residents or their representatives in writing notice of room changes.

A review of the facility's "Room Change/Roommate Assignment" policy dated 4/26/22, included...prior to changing a room or roommate assignment all parties involved in the change/assignments (e.g. residents and their representatives will be notified of change...documentation of a room change is recorded in the resident's medical record.... The policy did not include the resident and/or

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F 559	Continued From page 10 representative will receive written notice, including the reason for the change, before the resident's room or roommate in the facility was changed. NJAC 8:39-4.1(a)(13)	F 559		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the [redacted], and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 609		8/26/22

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F 609	Continued From page 11 by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an allegation of *Ex Order 26. 4B1* that occurred on *Ex Order 26. 4B1*. This deficient practice was identified for 1 of 3 residents (Resident #55) reviewed for *Ex.Order 26.4(b* and was evidenced by the following: On 7/22/22 at 10:54 AM, the surveyor observed Resident #55 in their *Ex Order 26. 4B1* in the hallway approach another resident (Resident #28) in their *Ex Order 26. 4B1* and he/she *Ex Order 26. 4B1* the back of the other resident's *Ex Order 26. 4B1* while making grunting noises. The surveyor observed Resident #28 try to propel themselves away from Resident #55, but the resident was unable to maneuver around the housekeeping cart in the hallway. Resident #28 called out *Ex Order 26. 4B1* and grabbed a broom off the housekeeping cart as Resident #55 attempted to grab the back handle of Resident #28's *Ex Order 26. 4B1*. There was no staff present at this time, so the surveyor looked down the hallway and saw an Occupational Therapist (OT) who the surveyor called for help. The surveyor told the OT what they observed, and the OT removed Resident #28 from the hallway. The surveyor reviewed the medical record for Resident #55. A review of the Admission Record face sheet reflected that the resident was admitted to the facility in *Ex Order 26. 4B1* with diagnoses which included *Ex Order 26. 4B1*	F 609	F609(D) How will the corrective action will be accomplished for those resident found to have been affected by the deficient practice. The facility completed and reported the allegation of *Ex Order 26. 4B1* for resident #55. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will recur. Audit was conducted to ensure no other *Ex Order 26. 4B1* occurred. Staff was in-serviced to report all allegations or *Ex Order 26. 4B1* to the supervisor DON and or Administrator. Administrator, DON or designee will investigate and report all allegations of abuse to the DOH immediately , or within 2 hours if injury is noted , no less than 24hours if no injury is noted. The managerial staff was in serviced on all events that should be reported to the appropriate parties including DOH, Ombudsman, family and local authorities. How the facility will monitor monitor its corrective action to ensure that the	

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	315152	A. BUILDING _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	301 UNION STREET HACKENSACK, NJ 07601

(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 609	Continued From page 12 Ex Order 26. 4B1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated 6/17/22, reflected a brief interview for mental status (BIMS) score of Ex Order 26. 4B1, which indicated Ex Order 26. 4B1 [redacted]. A review of the Progress Notes reflected a Nursing/Clinical note dated Ex Order 26. 4B1 at 7:51 PM, that the writer (Registered Nurse (RN)) was told by other nursing staff that there was an Ex Order 26. 4B1 between Resident #55 and Resident #12 around 7:05 PM when I was on break. Resident #55 Ex.Order 26.4(b)(1) themselves to Resident #12 who was sitting in their Ex Order 26. 4B1 by the nurse's station and Resident #55 kicked Resident #12 in their Ex Order 26. 4B1. The residents were immediately separated by nursing staff who witnessed the Ex Order 26. 4B1 and Resident #55 was directed back to their room. On 7/25/22 at 9:00 AM, the surveyor requested from the Director of Nursing (DON) all investigations for Resident #55 for the past two years. On Ex Order 26. 4B1 at 10:48 AM, the DON provided the surveyor with the requested investigations and confirmed they were all the investigation completed for Resident #55 since 2021. The surveyor reviewed the investigations for Resident #55 which did not include the Ex Order 26. 4B1 [redacted] documented in the Progress Notes on Ex Order 26. 4B1. On 7/26/22 at 9:39 AM, the DON informed the	F 609	deficient practice will not recur. DON or designee will ensure that all allegation or Ex Order 26. 4B1 [redacted] or bodily injury will be reported in timely manner. Audit weekly x 4 weeks then monthly for 3 months and quarterly x 3 months. DON or designee will report findings of audit to the Administrator and Quality Assurance Committee quarterly.	

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F 609	Continued From page 13 surveyor that last night while reviewing Resident #55's medical record, she noticed that Resident #55 Ex.Order 26.4(b) Resident #12 in Ex Order 26. 4B1, but she was not the DON at that time. The DON stated that she called the previous DON (DON #2) who stated that he thought there was a Ex Order 26. The surveyor asked what a Ex Order 26. 4B1 was, and the DON responded it was just an investigation. The surveyor asked the DON to provide them with a copy and asked if the Ex Order 26. 4B1 was reported to the NJDOH. The DON responded no and acknowledged that the Ex Order 26. 4B1 should have been since it was an allegation of Ex Order 26. 4B. On 7/28/22 at 10:51 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), and the survey team confirmed that the Ex Order 26. 4B1 from Ex Order 26. 4B1 was not reported to the NJDOH. A review of the facility's "Abuse Investigation and Reporting" policy dated revised July 2017, included all reports of Ex Order 26. 4B, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source Ex Order 26. 4B1 shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported... NJAC 8:39-9.4(e)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		8/26/22

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F 610	Continued From page 14 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential [redacted], neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the [redacted], and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, the facility failed to thoroughly investigate an instance of [redacted] that occurred on 2/17/22. This deficient practice was identified for 1 of 3 residents (Resident #55) reviewed for [redacted], and evidenced by the following: On 7/22/22 at 10:54 AM, the surveyor observed Resident #55 in their [redacted] in the hallway approach another resident (Resident #28) in their [redacted] and he/she kicked the back of the other resident's [redacted] while making grunting noises. The surveyor observed Resident #28 try to propel themselves away from Resident #55, but the resident was unable to maneuver around the housekeeping cart in the hallway. Resident #28 called out [redacted] and grabbed a broom off the housekeeping cart as Resident #55 attempted to grab the back handle of Resident	F 610	F610(D) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. An investigation was completed and reported for resident #55. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur.	

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F 610	Continued From page 15 #28's Ex Order 26. 4B1. There was no staff present at this time, so the surveyor looked down the hallway and saw the Occupational Therapist (OT) who the surveyor called for help. The surveyor told the OT what they observed, and the OT removed Resident #28 from the hallway. The surveyor reviewed the medical record for Resident #55. A review of the Admission Record face sheet reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, reflected a brief interview for mental status (BIMS) score of Ex Order 26. 4B1, which indicated Ex Order 26. 4B1. A review of the Progress Notes reflected a Nursing/Clinical Note dated Ex Order 26. 4B1 at 7:51 PM, that the writer (Registered Nurse (RN #1)) was told by other nursing staff that there was an Ex Order 26. 4B1 between Resident #55 and Resident #12 around 7:05 PM when I was on break. Resident #55 Ex Order 26. 4B1 themselves to Resident #12 who was sitting in their Ex Order 26. 4B1 by the nurse's station and Resident #55 kicked Resident #12 in their Ex Order 26. 4B1. The residents were immediately separated by nursing staff who witnessed the Ex Order 26. 4B1 and Resident #55 was directed back to their room.	F 610	The managerial staff was in-serviced on all events that should be investigated. All allegations or Ex Order 26. 4B1 will be reported to the supervisor, DON and/or Administrator. The Administrator, DON or designee will investigate all allegations of abuse and report to appropriate parties including DOH, Ombudsman ,family and local authorities. How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. DON or designee will conduct audits weekly x 4 weeks then monthly for 3 months and quarterly x 3 months to ensure all allegations or abuse are investigated and reported to DOH in a timely manner. DON or designee will report findings of audit to the Administrator and Quality Assurance Committee quarterly.	

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F 610	Continued From page 16 A review of an additional Nursing/Clinical Note dated [redacted] at 9:03 PM, reflected that complete body check was done on Resident #55 with no apparent injury, no complaint of pain and any discomforts from the [redacted] with Resident #12. A review of a Social Services Note dated [redacted] at 2:45 PM, reflected that the Undersigned (Director of Social Services (DSS)) met with Resident #55 and the RN/Supervisor #1 as a witness and resident was counseled to do not [redacted] any resident or staff. Resident educated to get staff member if they feel upset, angry to deescalate any issues before it arises. Resident has [redacted] A review of an additional Social Services Note dated [redacted] at 3:38 PM, reflected that the DSS and the RN/Supervisor #1 provided a picture book to assess Resident #55's memory. The resident was provided with three words to remember and shown pictures to point to recall. The BIMS score was assessed at a [redacted] which indicated [redacted]. There were no additional Progress Notes regarding the [redacted]. A review of the annual MDS from the period of the [redacted] on [redacted] dated [redacted], reflected that the resident had a BIMS score of [redacted], which indicated [redacted]. A review of [redacted] indicated that the resident had [redacted]; sometimes makes self understood with regards to ability limited to making concrete requests; and	F 610		

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F 610	Continued From page 17	F 610		

usually understands others with regards to misses some part/intent of message but comprehends most conversation.

On 7/25/22 at 9:00 AM, the surveyor requested from the Director of Nursing (DON) all investigations for Resident #55 for the past two years.

On 7/25/22 at 10:48 AM, the DON provided the surveyor with the requested investigations and confirmed they were all the investigation completed for Resident #55 since Ex Order 26.

The surveyor reviewed the investigations for Resident #55 which did not include the *Ex Order 26. 4B1* documented in the Progress Notes on Ex Order 26. 4B1.

On 7/26/22 at 9:39 AM, the DON informed the surveyor that last night while reviewing Resident #55's medical record, she noticed that Resident #55 Ex.Order 26.4(b) Resident #12 in *Ex Order 26. 4B1*, but she was not the DON at that time. The DON stated that she called the previous DON (DON #2) who stated that he thought there was a Ex Order 26 . The surveyor asked what a Ex Order 26. 4B1 was, and the DON responded it was just an investigation. The surveyor asked the DON to provide them with a copy.

On 7/26/22 at 10:09 AM, the DON provided the surveyor with a handwritten accident report dated Ex Order 26. 4B1 at 7:05 PM; Ex Order 26. 4B1 occurred Ex Order 26. 4B1. When the surveyor asked why the investigation was handwritten and not typed like the other investigations provided, the DON stated that Ex Order could not speak to it. When asked what actions the facility took to ensure Resident #55 did not

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F 610	Continued From page 18	F 610		

Ex.Order 2 any other residents, the DON stated that the resident followed up with the Ex Order 26. 4B1 and was Ex.Order 26.4(b)(1) anyone.

At this time the surveyor reviewed the Ex Order 26. 4B1 report with the DON, the part of the report that indicated a signature for the person preparing the report, Medical Director and Administrator was blank and the previous DON (DON #2) signed but did not date; the documents reviewed indicated medical records and statements; actions taken during this investigation was not applicable; three staff members were listed as people interviewed RN/Supervisor #1, RN/Supervisor #2, and Licensed Practical Nurse (LPN #1); and the conclusion was resident was seen by Ex Order 26. 4B1 on Ex Order 26. 4B1 with no changes in medicine and the resident was educated to Ex.Order 26.4(b)(1) other residents. There were no statements from the three people interviewed included. The DON could not speak to these statements. The DON stated that LPN #1 no longer worked at the facility but RN/Supervisor #1 and RN/Supervisor #2 still worked at the facility. The surveyor requested their telephone numbers.

On 7/26/22 at 11:11 AM, the surveyor interviewed RN/Supervisor #1 via telephone who stated that investigations were typically completed by the DON or the Assistant Director of Nursing (ADON), but the primary nurse would start an investigation by talking to the resident's Certified Nursing Aide (CNA). RN/Supervisor #1 stated that the staff interview would be paraphrased in the electronic medical record in the Ex Order 26. 4B1 report. RN/Supervisor #1 stated that night he was at the Nurse's Station and observed Resident #55 Ex Order 26. 4B1 themselves to the Nurse's

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F 610	Continued From page 19	F 610		

Station for a snack and them Ex Order 26. 4B1 themselves in their Ex Order 26. 4B1 to Resident #12 and Ex.Order 26.4(b) him/her in Ex Order 26. 4B1. RN/Supervisor #1 stated the residents were separated.
RN/Supervisor #1 stated that he could not recall if any documented interventions were put into place after the Ex Order 26. 4B1. RN/Supervisor #1 stated Resident #55 was Ex.Order 26.4(b)(1) I and would need to *Ex Order 26. 4B1* to listen. The resident would not automatically do what you told them to do.

On 7/26/22 at 12:07 PM, the surveyor interviewed RN/Supervisor #2 who stated that she did not witness the Ex Order 26. 4B1 on Ex Order 26. 4B1 but was called to the floor after the Ex Order 26. 4B1 RN/Supervisor #2 stated for *Ex Order 26. 4B1*, statements were documented in the electronic medical record. RN/Supervisor #2 stated that the purpose of investigation was to determine what happened and why it happened to prevent the situation from occurring again. RN/Supervisor #2 stated she spoke with LPN #1 who was a per diem nurse who no longer worked at the facility, and she obtained her statement. RN/Supervisor #2 stated LPN #1 did not witness Resident #55 Ex.Order 26. Resident #12 but she heard Resident #12 say Resident #55 Ex Order 26. 4B1 him/her. RN/Supervisor #2 stated that she completed the Ex Order 26. 4B1 report in the electronic medical record, but cannot speak to it. RN/Supervisor #2 stated Ex Order cannot recall a plan of care for Resident #55 after the Ex Order 26. 4B1.

On 7/26/22 at 12:54 PM, the surveyor interviewed the DSS who stated that Resident #55 had a *Ex Order 26. 4B1* with a BIMS score usually of a Ex Ord which indicated *Ex Order 26. 4B1*. The resident depending on their mood could follow direction. The surveyor asked if someone told the resident to stop doing

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F 610	Continued From page 20 something would they listen and the DSS replied Ex Order 26. 4B1 When the surveyor asked her how the telling the resident not to Ex Order 2 someone as documented in her note on Ex Order 26. 4B1 was an appropriate intervention for a resident with Ex Order 26. 4B1 , the DSS stated that Ex.Order 26.4(b)(1) was an intervention and could not speak further. On 7/28/22 at 10:51 AM, the DON and the Licensed Nursing Home Administrator (LNHA) in the presence of the ADON and the survey team confirmed the investigation provided to the surveyor for the Ex Order 26. 4B1 on Ex Order 26. 4B1 , which was dated Ex Order 26. 4B1 , was not a complete investigation. The DON also confirmed this Ex Order 26. 4B1 was not reported to the New Jersey Department of Health. A review of the facility's 'Ex Order 26. 4B1 Ex Order 26. 4B1 policy dated Revised December 2016, included all altercations, including those that may represent Ex Order 26. 4B1 , shall be investigated and reported to the Nursing Supervisor, the Director of Nursing Services and to the Administrator....if two residents are involved in an altercation staff will:...identify what happened, including what might have led to the Ex Order 26. 4B1 on the part of one or more of the individuals involved in the Ex Order 26. 4B1 ...review the events with the Nursing Supervisor and Director of Nursing, and possible measures to try to prevent additional Ex Order 26. 4B1 ...document in the resident's clinical record all interventions and their effectiveness...complete a "Report of Ex Order 26. 4B1 form and document the Ex Order 26. 4B1 findings, and any corrective measures taken in the resident's medical/clinical record...	F 610		

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F 610	Continued From page 21 A review of the facility's "Ex Order 26. 4B1 Investigation and Reporting" policy dated revised July 2017, included all reports of Ex Order 26. 4B, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source Ex Order 26. 4B1 shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of Ex Order 26. 4B investigations will also be reported... Refer to F609	F 610		
F 656 SS=D	NJAC 8:39-4.1(a)5; 27.1(a) 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	F 656		8/26/22

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F 656	Continued From page 22 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 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 an appropriate comprehensive, person-centered care plan for a resident with known Ex Order 26. 4B1 to prevent additional Ex Order 26. 4B1 with residents. This deficient practice was identified for 1 of 25 residents (Resident #55) reviewed for comprehensive care plans, and was evidenced by the following: On 7/22/22 at 10:54 AM, the surveyor observed Resident #55 in their Ex Order 26. 4B1 in the hallway approach another resident (Resident #28) in their Ex Order 26. 4B1 and he/she NJ Exec. Order 26: the back of the other resident's Ex Order 26. 4B1 while making grunting noises. The surveyor observed Resident #28 try to Ex Order 26. 4B themselves away from Resident #55,	F 656	F656(D) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The care plan was updated immediately for resident #55 How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measures will be put into place or	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	301 UNION STREET HACKENSACK, NJ 07601

(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 656	Continued From page 23 but the resident was unable to maneuver around the housekeeping cart in the hallway. Resident #28 called out [redacted] and grabbed a broom off the housekeeping cart as Resident #55 attempted to grab the back handle of Resident #28's [redacted]. There was no staff present at this time, so the surveyor looked down the hallway and saw the Occupational Therapist (OT) who the surveyor called for help. The surveyor told the OT what they observed, and the OT removed Resident #28 from the hallway. The surveyor reviewed the medical record for Resident #55. A review of the Admission Record face sheet reflected that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], reflected a brief interview for mental status (BIMS) score of [redacted], which indicated [redacted]. A review of the Progress Notes reflected a Nursing/Clinical Note dated [redacted] at 7:51 PM, that the writer (Registered Nurse (RN)) was told by other nursing staff that there was an [redacted] between Resident #55 and Resident #12 around 7:05 PM when I was on break. Resident #55 [redacted] themselves to Resident #12 who was sitting in their [redacted] by the nurse's station	F 656	systemic changes will be made to ensure that the deficient practice will not recur. The staff was in-serviced regarding updating the care plans timely after any [redacted] of [redacted] to prevent additional [redacted]. The Interdisciplinary Care Planning team will meet to discuss all [redacted], [redacted] to develop, implement and update the person-centered care plan accordingly. How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. DON or designee will conduct audits weekly x 4 weeks then monthly for 3 months and quarterly x 3 months. DON or designee will report findings of audit to the Administrator and Quality Assurance Committee quarterly.	

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F 656	Continued From page 24	F 656		

and Resident #55 Ex Order 26. 4B1 Resident #12 in their Ex Order 26. 4B1. The residents were immediately separated by nursing staff who witnessed the Ex Order 26. 4B1 and Resident #55 was directed back to their room.

A review of the resident's comprehensive person-centered care plan included a focus area initiated on Ex Order 26. 4B1 and last revised on Ex Order 26. 4B1 for the resident's has a Ex Order 26. 4B1 and Ex Order 26. 4B1 related to Ex Order 26. 4B1 and unable to express self, [he/she] Ex Order 26. 4 others. Interventions included to Ex.Order 26.4(b)(1) and caregivers for Ex Order 26. 4B1. The care plan did not include the resident Ex.Order 26.4(b) residents or interventions to prevent the resident from Ex Order 26. 4B1 another resident.

On 7/26/22 at 11:11 AM, the surveyor interviewed the Registered Nurse/Supervisor (RN/Supervisor) who stated that care plans were updated as needed by the unit managers and the Assistant Director of Nursing (ADON). The RN/Supervisor stated at the time of Resident #55's Ex.Order 26.4(b)(1) with Resident #12, he was the Unit Manager and witnessed Resident #55 Ex.Order 2 Resident #12. The RN/Supervisor stated that after an Ex Order 26. 4B1 report was completed, usually the DON, ADON, or Unit Manager developed interventions to put into place in order to prevent the situation from re-occurring and the care plan was updated. The RN/Supervisor stated that he could not recall documenting any new interventions or updating the care plan after Resident #55's Ex Order 26. 4B1.

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F 656	Continued From page 25 On 7/27/22 at 12:05 PM, the surveyor interviewed the DON who stated that care plans were updated after an [redacted] with new interventions put in place to prevent the [redacted] from reoccurring. At this time, the surveyor reviewed the resident's care plan with the DON regarding the care plan revised by her on [redacted] for the focused area of the resident [redacted] others. The DON stated that she started working at the facility on [redacted], but could have been at the facility reviewing charts as part of the Corporate facility and updated the care plan then. The DON stated that she could not speak to the particulars of why she updated the resident's care plan on [redacted], but the DON acknowledged that care plan was not appropriate for a resident who [redacted] other residents, the DON stated that the resident must have [redacted] a staff member because those interventions were appropriate for staff members. A review of the facility's "Care Planning - Interdisciplinary Team" policy dated revised March 2022, included resident care plans are developed according to the timeframes and criteria established in 483.21; comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team... NJAC 8:39-11.2(e)	F 656		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		8/26/22

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F 658	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to a.) follow a physicians order for a Ex Order 26. 4B1 consultation for a resident who had a physical Ex Order 26. 4B1 with a resident on Ex Order 26. 4B1 which continued through the standard survey on 8/3/22 and b.) assess and updated a resident's Ex Order 26. upon admission to the facility in accordance with professional standards of nursing practice. This deficient practice was identified for 2 of 25 residents (Resident #36 and #55) reviewed for professional standards of nursing practice. 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	F 658	F658(E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Ex Order 26. 4B1 came to visit resident #55 for Ex Order 26. 4B1 on the same day, as per the Ex Order 26. 4B1 resident #55 refused service . The Social Worker spoke with resident #36 and updated the Ex Order 26. 4B1. Ex Order 26. 4B1 was updated and verified by resident and medical doctor. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The IDCP (Interdisciplinary Care Planning) team will meet to discuss the Ex Order 26. 4B1 and update , develop/implement comprehensive care plan to ensure that it meets professional standards of quality. The facility will in-service admitting nurses to ask alert and oriented new admission their Ex Order 26. 4B1. MD(medical doctor) will be informed about residents Ex Order 26. 4B1 preference and orders could be verified,	

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F 658	Continued From page 27 counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." The deficient practice was evidenced by the following: 1. On 7/22/22 at 10:54 AM, the surveyor observed Resident #55 in their Ex Order 26. 4B1 in the hallway approach another resident (Resident #28) in their Ex Order 26. 4B1 and he/she Ex.Order 26.4(b) the back of the other resident's Ex Order 26. 4B1 while making grunting noises. The surveyor observed Resident #28 try to Ex Order 26. 4B1 themselves away from Resident #55, but the resident was unable to maneuver around the housekeeping cart in the hallway. Resident #28 called out Ex Order 26. 4B1 and grabbed a broom off the housekeeping cart as Resident #55 attempted to grab the back handle of Resident #28's Ex Order 26. 4B1. There was no staff present at this time, so the surveyor looked down the hallway and saw the Occupational Therapist (OT) who the surveyor called for help. The surveyor told the OT what they observed, and the OT removed Resident #28 from the hallway. The surveyor reviewed the medical record for Resident #55. A review of the Admission Record face sheet reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted].	F 658	update and ordered. In house nurse practitioner will meet with residents and discuss Ex Order 26. 4B1, orders will be update as per residents wishes. Social Worker will meet with resident, family and or responsible party and discuss Ex Order 26. 4B1. Status will be verified by resident, responsible party, and md. Orders will be obtained. The facility will in-service staff on the DOT system. Dots will be placed on residents name wrist bracelet, this DOT will identify resident preferred Ex Order 26. 4B1. The facility will in-service Ex Order 26. 4B1 to alert staff when residents refuses a consult. The facility will in-service Ex Order 26. 4B1 to document resident refusal of consult. How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. DON or designee will conduct audits weekly x 4 weeks then monthly for 3 months and quarterly x 3 months. DON or designee will report findings of audit to the Administrator and Quality Assurance Committee quarterly.	

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F 658	Continued From page 28	F 658		

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, reflected a brief interview for mental status (BIMS) score of Ex Order 26. 4B1, which indicated Ex Order 26. 4B1.

A review of the Progress Notes reflected a Nursing/Clinical Note dated Ex Order 26. 4B1 at 7:51 PM, that the writer (Registered Nurse (RN)) was told by other nursing staff that there was an Ex Order 26. 4B1 between Resident #55 and Resident #12 around 7:05 PM when I was on break. Resident #55 Ex.Order 26.4(b)(1) themselves to Resident #12 who was sitting in their Ex Order 26. 4B1 by the Nurse's Station and Resident #55 Ex.Order 26.4(b) Resident #12 in their Ex Order 26. 4B1. The residents were immediately separated by nursing staff who witnessed the Ex Order 26. 4B1 and Resident #55 was directed back to their room.

A review of the Order Summary Report reflected a physician's order (PO) dated Ex Order 26. 4B1 for a Ex Order 26. 4B1 consultation every shift for Ex Order 26. 4B1 discontinue once done.

On 7/25/22 at 12:41 PM, the surveyor requested from the Director of Nursing (DON) all of Resident #55's Ex Order 26. 4B1 consultations from the past year.

On 7/26/22 at 8:30 AM, the DON provided the surveyor with the Progress Notes for the Ex Order 26. 4B1 for the past year. This included only one Physician/Practitioner Progress Note for a Ex Order 26. 4B1 dated Ex Order 26. 4B1. At this time, the DON confirmed this was all the Ex Order 26. 4B1 Resident #55 had this year.

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F 658	Continued From page 29 On 7/27/22 at 11:15 AM, the Assistant Director of Nursing (ADON) stated that the Ex Order 26. 4B1 requested to speak to the surveyor and provided the surveyor with his phone number. On 7/27/22 at 11:17 AM, the surveyor interviewed the Ex Order 26. 4B1 who stated if the facility informed him there was an issue with a resident, he would come to the facility and see the resident. The Ex Order 26. 4B1 stated that if the resident refused to see him, he would not document that he came to visit but the resident refused to see him. When the surveyor asked why he would not document that the resident refused to see him or how would someone know that he attempted to see the resident, the Ex Order 26. 4B1 stated that he would expect the nurse to document a note that the resident refused to see the Ex Order 26. 4B1 that day. The Ex Order 26. 4B1 further stated that there was Ex Order 26. 4B1 for him to document the refusal and staff should document there was communication with him. The Ex Order 26. 4B1 stated that he expected the nurses to communicate if a resident needed to be seen and if there was a change in a resident's Ex.Order 26.4(b)(1), the nurse should communicate that to him. When asked specifically if the Ex Order 26. 4B1 to see Resident #55 in Ex Order 26. 4B1, the Ex Order 26. 4B1 responded, "I see between 10-15 people so there is no way I can remember everyone." The surveyor continued to review Resident #55's medical record. There was no documentation that the resident refused to see the Ex Order 26. 4B1. On 7/28/22 at 10:51 AM, the DON in the presence of the LNHA, ADON, and survey team stated that the Ex Order 26. 4B1 did come to see the	F 658		

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F 658	Continued From page 30 resident in [redacted], but the resident refused to see the [redacted] The DON confirmed that there was no documentation to corroborate this. The DON confirmed that it was the nurses responsibility to ensure that all physician's orders are followed through and that the [redacted] saw the resident. A review of the facility's "Behavioral Assessment, Intervention and Monitoring" policy dated revised February 2022, included the facility will provide and residents will receive behavioral health services as needed to attain or maintain the highest practical physical, mental and psychosocial well-being in accordance with comprehensive assessments and plan of care... A review of the facility's "Physician Orders: Obtaining and Transcribing" policy dated revised 2/10/22, included...notify other parties of orders as necessary, that is [i.e.] pharmacy, therapist, lab, consultant, etc. per center specific protocols... 2. On 7/27/22 at 10:45 AM, the surveyor observed Resident #36 in bed, awake and receiving a [redacted]. The resident was able to speak with the surveyor and informed the surveyor that their requested [redacted] was to have nothing done and to be a [redacted] in the event of an emergency. The resident informed the surveyor that they had already informed the facility of this request previously.	F 658		

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The surveyor reviewed the medical record for Resident #36.

A review of the Admission Record face sheet indicated the resident was initially admitted to the facility in [redacted], and most recently re-admitted in [redacted] with diagnosis which included [redacted].

A review of the most recent admission MDS dated [redacted], indicated the resident had a BIMS score of [redacted], which indicated [redacted].

A review of the "Social Service Admission Evaluation" dated effective [redacted], indicated the resident was to be [redacted] and had a [redacted] form was on file.

A review of the resident's paper medical record included an undated and unsigned [redacted] form which indicated [redacted].

A review of the resident's comprehensive care plan included a focus area initiated on [redacted], for an Advanced Directive with interventions that included [redacted].

A review of the Medication Review Report dated on or after [redacted], did not include a physician's

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F 658	Continued From page 32 order for [redacted].	F 658		

A review of three admission nursing assessments titled "Resident Evaluation with [redacted] Screen" indicated the following: effective date 5/24/22 advanced directive [redacted]; effective date 6/9/22 advanced directive [redacted] effective date [redacted] advanced directive [redacted]

On 7/27/22 at 10:53 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who confirmed the resident had no physician order for [redacted]. The LPN also stated that all residents were treated as [redacted] unless otherwise ordered, and residents with [redacted] orders might have a bracelet indicating [redacted].

On 7/27/22 at 11:05 AM, the surveyor interviewed the Unit Secretary (US) who informed the surveyor that the [redacted] should have been completed.

On 7/27/22 at 11:19 AM, the surveyor interviewed the lead Certified Nursing Assistant (CNA) who informed the surveyor that the resident should have a colored bracelet indicating [redacted]. The surveyor accompanied by the lead CNA went to Resident #36 to observe the [redacted] bracelet and the lead CNA was unable to locate the bracelet or determine the resident's [redacted].

On 7/27/22 at 11:28 AM, the surveyor interviewed the Director of Nursing (DON) who acknowledged that the resident's medical records were [redacted] and in a [redacted] situation, the facility would have to call the resident's emergency

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F 658	Continued From page 33 contacts to determine the Ex Order 26. 4B1 wishes. On 7/28/22 at 10:19 AM, the DON in the presence of the LNHA, ADON, and survey team confirmed the nurse should have communicated with the physician any changes in Ex Order 26. 4B1. The DON confirmed when a resident was admitted or re-admitted to the facility, the admitting nurse asked the resident what their Ex Order 26. 4B1 wishes were and documented it in the medical record as a standard of practice. The DON stated she spoke to the resident who confirmed they wanted to be a Ex Order 26. 4B1, and receive no Ex.Order 26.4(b)(1). A review of the facility's "Advance Directives" policy dated revised Ex Order 26. 4B1, included: ...11. The resident has the right to refuse treatment, whether or not he or she has an advance directive. A resident will not be treated against his or her own wishes...our facility has defined advanced directives as preferences regarding treatment options and include, but are not limited to:... Ex Order 26. 4B1 ...	F 658		
F 689 SS=G	NJAC 8:39-27.1(a) Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		8/26/22

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F 689	Continued From page 34 by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to prevent a [redacted] from the [redacted] by following the resident's plan of care during *Ex Order 26. 4B1* which resulted in [redacted]. This deficient practice was identified for 1 of 4 residents reviewed for accidents (Resident #11). The evidence was as follows: On 7/20/22 at 12:24 PM, the surveyor observed Resident #11 sitting up in a *Ex Order 26. 4B1* [redacted] wearing a [redacted] gown. The resident who appeared [redacted] stated to the surveyor that he/she had a [redacted] in the facility a few months ago when the Certified Nursing Aide (CNA #1) attempted to change his/her *Ex Order 26. 4B1* independently. The resident stated he/she had told CNA #1 [redacted] could not do it on [redacted] own and needed another CNA to assist [redacted], but CNA #1 continued to independently perform [redacted] mobility anyway, and it caused him/her to [redacted] out of the [redacted]. The resident stated he/she spent weeks in the [redacted] and had injured both their *Ex Order 26. 4B1* [redacted], resulting also in [redacted] The surveyor reviewed the medical record for Resident #11. A review of the Admission Record face sheet (an admission summary) reflected the resident was re-admitted to the facility in [redacted] with diagnoses that included a *Ex Order 26. 4B1* [redacted]	F 689	F689(G) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Certified Nursing Assistant (CNA) was educated regarding following resident plan of care. Competency evaluation completed for positioning on *Ex Order 26. 4B1* [redacted], care by two person assist for resident #11. How the facility will identify other residents having the potential to be affected by the same deficient practice. Resident #11 was *Ex Order 26. 4B1* affected. Any resident requiring two person assist in the facility has the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. Certified Nursing Assistant were re-educated regarding following the plan of care in the [redacted] for all residents including those requiring 2-person assist. All resident that needs assistance of two for positioning during *Ex Order 26. 4B1* [redacted], care will be placed on CNA's assignments daily. How the facility will monitor monitor its corrective action to ensure that the	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET HACKENSACK, NJ 07601**

(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 689	Continued From page 35 Ex Order 26. 4B1 [redacted] A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated Ex Order 26. 4B1 reflected that the resident had a brief interview for mental status score of Ex Order 26. 4B1, which indicated that the resident had a Ex Order 26. 4B1 [redacted]. It further reflected that the resident had exhibited no behaviors in the last seven days of the assessment. Section G used to assess the resident's functional status for Ex Order 26. 4B1 [redacted], included that the resident required extensive assistance with a Ex.Order 26.4(b)(1) [redacted] and Ex Order 26. 4B1 [redacted]. It further included that the resident had a Ex Order 26. 4B1 limitation to Ex Order 26. 4B1 [redacted] and Ex Order 26. 4B1 [redacted] to the Ex Order 26. 4B1 [redacted]. A review of the individualized comprehensive care plan reflected a focused area that Resident #11 had a risk for [redacted] that was initiated on Ex Order 26. 4B1. Interventions included to provide assistance, and to Ex Order 26. 4B1 as needed. The care plan was updated on Ex Order 26. 4B1 after a noted actual [redacted], and the care plan specified to include a two-person assist at all times with [redacted] and Ex Order 26. 4B1. The surveyor reviewed the progress notes for Resident #11 and identified that the resident had an actual [redacted] from the [redacted] on Ex Order 26. 4B1.	F 689	deficient practice will not recur. The DON/ADON or designee will monitor and perform surveillance to ensure that he CNAs are following the plan of care for patients that requires assistant of 2 for positioning on Ex Order 26. 4B1 [redacted]. Weekly surveillance will be done x 4 weeks , monthly x 3 months and then quarterly x 3 months. The DON/ADON or designees will report findings of surveillance to the Administrator and Quality Assurance Committee quarterly.	

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A review of the Progress Notes reflected a Nurses Note dated 1/14/22 at 1:40 PM. The note indicated, "Notified by staff, resident sustained [redacted] inside bedroom. CNA was present in the room and witnessed [redacted] CNA states that [redacted] occurred while she was performing a diaper change. Resident found *Ex Order 26. 4B1* [redacted] while hanging on to the [redacted] railing. [Resident #11] then was *Ex Order 26. 4B1* [redacted] by staff and kept comfortable. Upon assessment, resident states [he/she] *Ex Order 26. 4B1* [redacted] but did not identify exact location of pain. Noted *Ex Order 26. 4B1* [redacted] to *Ex Order 26. 4B1* [redacted], Ex.Order 26.4(b)(1) [redacted] administered. Resident has difficulty raising [his/her] *Ex Order 26. 4B1* [redacted]. Patient kept comfortable on the floor with pillow under [his/her] head until Emergency Medical Technician [EMT] arrived. Medical Doctor [MD] made aware, and family notified. Order received to send to Ex.Order 26.4(b)(1) [redacted]."

The surveyor requested the *Ex Order 26. 4B1* [redacted] investigative report for Resident #11's [redacted] that occurred on *Ex Order 26. 4B1* [redacted].

A review of the *Ex Order 26. 4B1* [redacted] Report dated *Ex Order 26. 4B1* [redacted], included the CNA #1 staff statement *Ex Order 26. 4B1* [redacted]

[redacted]

A review of the most recent annual MDS dated *Ex Order 26. 4B1* [redacted], reflected a brief interview for mental status (BIMS) score of *Ex Order 26. 4B1* [redacted], which indicated a *Ex Order 26. 4B1* [redacted].

On 7/26/22 at 10:08 AM, the surveyor requested the corresponding *Ex Order 26. 4B1* [redacted] records for Resident

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F 689	Continued From page 37 #11. A review of the Ex Order 26. 4B1 records revealed Resident #11 was Ex Order 26. 4B1 from Ex Order 26. 4B1 until Ex Order 26. 4B1. The report further revealed Resident #11 was seen by the Ex.Order 26.4(b)(1) on 1/16/22 whose impression was resident sustained "..Ex Order 26. 4B1 and a Ex Order 26. 4B1 after a Ex Order 26. 4B1 out of Ex Order 26. 4B1 On 7/26/22 at 11:11 AM, the surveyor conducted a telephone interview with the Registered Nurse/Unit Manager (RN/UM) who worked on Ex Order 26. 4B1. The RN/UM stated he remembered CNA #1 had called him into the room and told him Ex Order 26. 4B1. The RN/UM stated he went into the room and assisted Resident #11 to the ground, and assessed the resident and he/she had no apparent Ex.Order 26.4(b)(1) at the time except a Ex Order 26. 4B1 on his/her Ex Order 26, and no sign of Ex Order 26. 4B1 or Ex Order 26. 4B1. The RN/UM also stated Resident #11 did complain of Ex.Order 26.4(b)(1) around the Ex Order 26. 4B1 but complained of generalized pain, so the resident remained on the floor until Emergency Medical Services (EMS) could Ex Order 26. 4B1 them to the Ex Order 26. 4B1 for further assessment and treatment. The RN/UM stated he believed CNA #1 was in the room alone at the time of the Ex Orde, and that CNA #1 should have called someone into the room to assist her in moving the resident during care especially with a resident that Ex Order 26 in size. He added that you would need an extra hand to ensure the resident's safety. The RN/UM stated he did not believe the resident had a history of Ex Order 2, but knew resident required a Ex.Order 26.4(b)(1) to get them out of Ex Order 26 When the surveyor asked the RN/UM if there were any circumstances when one staff would be sufficient when a resident was assessed to require aEx.Order 26.4(b)(1)	F 689		

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assistance, and the RN/UM responded, "No." He continued that staff must get someone to come help them with that resident's care. He added that in general, if they were a Ex.Order 26.4(b)(1) we instructed staff to get someone to ensure nothing happens to the resident or staff member such as [redacted] or injury. The RN/UM stated prior to this [redacted], he had never had any concerns with CNA #1's transfers but he spoke to CNA #1 about having a second staff member when there is a Ex.Order 26.4(b)(1) required.

On 7/26/22 at 12:13 PM, the surveyor observed Resident #11 in bed on an air mattress with their head elevated. There was lunch on the resident's bedside table. The resident informed the surveyor he/she was [redacted] now of another [redacted] from the [redacted]. The resident added that since the [redacted], their [redacted] was [redacted].

On 7/26/22 at 12:52 PM, the surveyor interviewed the Director of Rehabilitation Services (DRS) who stated since Resident #11 could not get out of [redacted] or perform [redacted], the resident required an Ex.Order 26.4(b)(1) physical assist. One staff member would perform the care while the other staff member maintained the resident's position, for safety. The DRS stated Resident #11 was not on [redacted] before the [redacted], but once they returned from the [redacted], Resident #11 was placed on both Ex.Order 26.4(b)(1) from [redacted]. The DRS stated that per the [redacted] records, Resident #11 had a [redacted] which resulted in a [redacted] of the [redacted] and a [redacted]

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Ex Order 26. 4B1 [redacted]. The RDS stated there were no circumstances when a Ex.Order 26.4(b)(1) [redacted] should be performed alone, as it could cause injury to staff as well as the resident.

On 7/27/22 at 10:33 AM, the surveyor interviewed CNA #1 who was assigned to Resident #11 on Ex Order 26. 4B1 [redacted]. The CNA #1 stated she has worked at the facility for about a year and three months. She stated that she starts her shift in the morning with gathering her supplies and checking on her residents based on the assignment she was given that day. She stated that there are many ways in which she can find out what kind of care or level of assistance a resident needs, such as asking the resident directly, reviewing the Kardex or care plan for the resident, look on the resident's chart, or ask the nurse.

CNA #1 stated that she was familiar with Resident #11 and that the resident required Ex.Order 26.4(b)(1) because he/she had a Ex Order 26. 4B1 The CNA #1 stated that at the time she cared for the resident, she had only been working at the facility for about six months and didn't know about a Kardex (CNA care plan) system as she was still "trying to learn things." The CNA #1 stated that she believed that the resident required one person to assist.

The surveyor inquired about the Ex Order 26. 4B1 that occurred on Ex Order 26. 4B1 [redacted]. The CNA #1 stated after washing the front of the resident, she needed to turn the resident to their side to perform washing to the back, so she independently pulled the sheet that was under Resident #11 and crossed their Ex Order 2 [redacted]. CNA #1 stated she had one hand on the resident holding them and the other hand she held a washcloth, when Resident #11's Ex Order 26. 4B1 [redacted]

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had begun to [redacted] off the [redacted], she immediately grabbed the [redacted] controller and lowered the [redacted] to the floor, because she said she knew she could not independently hold the resident's weight. Once the [redacted] was lowered, she tried to ease the resident down to the floor and onto their [redacted] and she called out to the Housekeeper who called the RN/UM. She stated that the resident was not complaining of [redacted], but was [redacted] from [redacted] out of the [redacted] and was [redacted] than in pain. The CNA #1 told the surveyor that she had the resident on her assignment once more when the resident returned to the facility, and another male CNA assisted her that day. The surveyor asked CNA #1 how many residents were on her assignment that day and CNA #1 stated [redacted] believed 11 or 12, but usually it was 13 residents. CNA #1 stated she was sure there were only four CNA's that day because if there had been five CNA's, she would not have had Resident #11's room on her assignment.

On 7/27/22 at 12:15 PM, the surveyor reviewed the Daily Assignment Sheet provided by the Assistant Director of Nursing (ADON) which revealed on 1/14/22 during the 7:00 AM to 3:00 PM day shift, they had four CNA's assigned to work on the third floor. At that same time, the surveyor reviewed the facility provided census for the third floor on 1/14/22 which revealed there were a total of 54 residents residing on the third floor that day, making the ratio one CNA to every 13 residents.

On 7/27/22 at 12:20 PM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The DON acknowledged that according to the [redacted] investigation CNA #1

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independently turned Resident #11 during care, but according to the resident's care plan and quarterly MDS dated Ex Order 26. 4B1 prior to the Ex Orde, the resident required a NJ Exec. Order 26:4.b.1 for Ex Order 26. 4B1 and NJ Exec. Order 26:4.b. Together the surveyor and the DON reviewed the facility provided Ex Order 26. 4B1 for Resident #11's Ex Orde investigation's conclusion which revealed "In conclusion resident sustained a witnessed Ex Orde when CNA #1 turned [him/her] and [he/she] was lowered to the floor. The DON acknowledged there was no mention of cause regarding the one-person assist when NJ Exec. Order 26:4.b.1 was required. The DON further acknowledged there was no documented re-education provided to CNA #1 directly after the Ex Order 26. 4B1 and no competencies were immediately performed. The DON stated it was important that CNA #1 should have been re-educated regarding safe care for Resident #11 regarding Ex Order 26. 4B1 to prevent future accidents. The DON was able to provide the surveyor a copy of the CNA Kardex at the time of the the Ex Orde that occurred on Ex Order 26. 4B1. The Kardex revealed that the resident required one person for Ex Order 26. 4B1. Ex Order 26. 4B1 [redacted]. The DON stated that the resident was one person for Ex Order 26. 4B1, but confirmed if the resident was going to be turned during the Ex Order 26. 4B1 process, it would require two people to turn the resident. At that time also, the surveyor and the DON reviewed the facility provided census for 1/14/22 as well as the Daily Assignment Sheet for the CNA's for 1/14/22. The DON acknowledged there were four CNA's assigned to the 7:00 AM to 3:00 PM day shift for the third floor and that the resident census for that day was 54, a ratio of one CNA to every 13

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F 689	Continued From page 42 residents. The DON acknowledged that the resident had Ex Order 26. 4B1 and an unplanned Ex Order 26. 4B1. There were no other Ex Order 26. 4B1 regarding the CNA #1 or Resident #11. A review of the facility's "Bath, Bed policy" revised 2018, included under General Guidelines 1. Review the care plan to determine any special needs of the resident...a. Instruct the resident to turn on his/her side with his/her back toward you. (Note: Be sure the side rail is up on the opposite side of the Ex Order to prevent the resident from Ex Order 26. 4B [redacted].) b. If the resident cannot turn by himself or herself, assist as needed... A review of the facility's "Identifying Neglect" policy dated 2/10/22, included preventing resident neglect is a priority throughout all levels of this organization..."neglect" is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical pain, mental anguish, or emotional distress; any situation in which the resident's care needs are known (or should be known) by staff (based on assessment and care planning), and those needs are not met due to other circumstances, can be defined as neglect; circumstances that lead to neglect: ...lack of sufficient staffing...poor staff oversight and/or performance evaluations.... NJAC 8:39-27.1 (a)	F 689		
F 690 SS=D	Ex Order 26. 4B1 [redacted] CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is Ex Order 26. 4B1 and bowel on	F 690		8/26/22

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F 690	Continued From page 43 admission receives services and assistance to maintain [redacted] unless his or her clinical condition is or becomes such that [redacted] is not possible to maintain. §483.25(e)(2)For a resident with [redacted], based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an [redacted] is not [redacted] unless the resident's clinical condition demonstrates that [redacted] was necessary; (ii) A resident who enters the facility with an [redacted] or subsequently receives one is assessed for removal of the [redacted] as soon as possible unless the resident's clinical condition demonstrates that [redacted] is necessary; and (iii) A resident who is [redacted] of bladder receives appropriate treatment and services to prevent [redacted] and to restore [redacted] to the extent possible. §483.25(e)(3) For a resident with fecal [redacted], based on the resident's comprehensive assessment, the facility must ensure that a resident who is [redacted] receives appropriate treatment and services to restore as much [redacted] function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure a.) ensure [redacted] care was performed and documented every shift and b.) [redacted] output was documented every shift in accordance	F 690	F690(D) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 690	Continued From page 44 with a physician's order. This deficient practice was identified for 1 of 2 residents (Resident #36) reviewed for Ex Order 26. 4B1 and was evidenced by the following: On 7/27/22 at 10:45 AM, the surveyor observed Resident #36 in bed, awake and receiving a Ex Order 26. 4B1 . The resident had a Ex Order 26. 4B1 in a Ex Order 26. 4B1 hanging from the bed frame below the resident's bed. The surveyor reviewed the medical record for Resident #36. A review of the Admission Record face sheet reflected the resident was initially admitted to the facility in Ex Order 26. 4B1 with medical diagnosis which included Ex Order 26. 4B1 . A review of the admission Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1 , reflected the resident had a brief interview for mental status (BIMS) score of Ex Order 26. 4B1 , which indicated a Ex Order 26. 4B1 . A review of the June 2022 Treatment Administration Record (TAR) included a physician's order dated Ex Order 26. 4B1 for Ex Order 26. 4B1 output every shift. The corresponding dates and shifts that were not documented as follows: 6/24/22 3 PM - 11 PM shift 6/25/22 7 AM - 3 PM shift	F 690	Resident #36 was assessed , no negative outcome noted. How the facility will identify other residents having the potential to be affected by the same deficient practice. Resident #36 was affected. All other residents with Ex Order 26. 4B1 have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. All nurses were in-service on signing and documenting the urine outputs. All nurses were in-serviced on providing and signing Ex Order 26. 4B1 Ex Order 26. 4B1 care every shift. Weekly audits of Ex Order 26. 4B1 for 4 weeks then monthly will be done to ensure signing of Ex Order 26. 4B1 and documentation or Ex Order 26. 4B1 . How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. DON or designee will conduct audits treatment records weekly x 4 weeks, monthly x 3 months and quarterly x 3 months. DON or designee will report findings to Administrator and the Quality Assurance Performance improvement committee quarterly.	

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F 690	Continued From page 45 6/26/22 7 AM - 3 PM shift 6/28/22 7 AM - 3 PM shift A review of the July 2022 TAR included a physician's order dated Ex Order 26. 4B1 and discontinued Ex Order 26. 4B1 for Ex Order 26. 4B1 output every shift. The corresponding dates and shifts were not documented as follows: 7/1/22 7 AM - 3 PM shift 7/1/22 3 PM - 11 PM shift 7/4/22 3 PM - 11 PM shift A further review of the July 2022 TAR reflected an additional physician's order dated Ex Order 26. 4B1 for Ex Order 26. 4B1 output every shift. The corresponding dates and shifts were not documented as follows: 7/16/22 7 AM - 3 PM shift 7/17/22 3 PM - 11 PM shift 7/18/22 11 PM - 7 AM shift 7/19/22 3 PM - 11 PM shift 7/20/22 3 PM - 11 PM shift 7/23/22 7 AM - 3 PM shift A review of the Ex Order 26. 4B1 Tar reflected a physician's order dated Ex Order 26. 4B1 for Ex Order 26. 4B1 care every shift for Ex Order 26. 4B1. The corresponding dates and shifts were not documented as follows: 7/16/22 7 AM - 3 PM shift 7/18/22 11 PM - 7 AM shift 7/19/22 3 PM - 11 PM shift 7/20/22 3 PM - 11 PM shift 7/22/22 7 AM - 3 PM shift On 7/28/22 at 09:38 AM, the surveyor interviewed the lead Certified Nursing Assistant (CNA) who	F 690		

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	315152	A. BUILDING _____ B. WING _____	08/03/2022

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F 690	Continued From page 46 stated that CNAs emptied the Ex Order 26. 4B1 for residents with Ex Order 26. 4B1 and reported the total amount of Ex Order 26. to the nurses, who then documented the output. On 7/28/22 at 09:51 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated the facility nurses were responsible for Ex Order 26. 4B1 as ordered and the CNAs usually emptied the Ex Order 26. 4B1 and reported the amount of Ex Order 26. to the nurses for documentation. The LPN further stated that Ex Order 26. 4B1 and urine output monitoring was important to monitor for resident's Ex Order 26. production and Ex Order 26. 4B1 On Ex Order 26. 4B1 at 10:19 AM, the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), and the survey team, confirmed the missing documentation for the above dates for Resident #36's Ex Order 26. 4B1 and Ex Order 26. 4B1. The DON further acknowledged that if it was not documented, it was considered not done. Review of the facility's Ex Order 26. 4B1 policy dated revised February 2022 included, The purpose of this procedure is to prevent Ex Order 26. 4B1 ...Input/Output: 2. Maintain an accurate record of the resident's daily output, per facility policy and procedure...Documentation: The following information should be recorded in the resident's medical record: 1. The date and time that Ex Order 26. 4B1 was given; 2. The name and title of the individual(s) giving Ex Order 26. 4B1; 3. All assessment data obtained when giving Ex Order 26. 4B1 ...	F 690		

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F 690	Continued From page 47 NJAC 8:39- 19.4 (a)5; 27.1 (a)	F 690		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) 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 ensure that the physician responsible for the supervising the care of a *Ex Order 26. 4B1* resident conducted face-to-face visits and wrote progress notes at least every thirty days had been seen since March of 2022. This deficient practice was identified for 1 of 3 residents (Resident #55) reviewed for physician visits and was evidenced by the following:	F 712	F712(E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The primary physician came to conduct face-face visit will patient #55 How the facility will identify other residents	8/26/22

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F 712	Continued From page 48 On 7/22/22 at 10:54 AM, the surveyor observed Resident #55 in their Ex Order 26. 4B1 in the hallway approach another resident (Resident #28) in their Ex Order 26. 4B1 and he/she Ex Order 26. 4B1 the back of the other resident's Ex Order 26. 4B1 while making grunting noises. The surveyor observed Resident #28 try to propel themselves away from Resident #55, but the resident was unable to maneuver around the housekeeping cart in the hallway. Resident #28 called out Ex Order 26. 4B1 and grabbed a broom off the housekeeping cart as Resident #55 attempted to grab the back handle of Resident #28's Ex Order 26. 4B1. There was no staff present at this time, so the surveyor looked down the hallway and saw the Occupational Therapist (OT) who the surveyor called for help. The surveyor told the OT what they observed, and the OT removed Resident #28 from the hallway. The surveyor reviewed the medical record for Resident #55. A review of the Admission Record face sheet reflected that the resident was admitted to the facility in Ex Order 26. 4B1 with diagnoses which included Ex Order 26. 4B1 [redacted]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, reflected a brief interview for mental status (BIMS) score of Ex Order 26. 4B1, which indicated Ex Order 26. 4B1. A review of the electronic Progress Notes	F 712	having the potential to be affected by the same deficient practice. Resident #55 was affected. All residents in the facility have potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The Administrator/DON will reach out/educate all physicians to have face-face visit and document at least every 30 days. How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. DON or designee will audit the records weekly x 4 weeks then monthly for 3 months and quarterly x 3 month. DON or designee will report findings of audit to the Administrator and Quality Assurance improvement Committee quarterly.	

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F 712	Continued From page 49	F 712		

reflected that there were no documented primary care physician or nurse practitioner notes from January 2022 through the time in which the surveyor was reviewing the resident's medical record. There was only one Physician/Practitioner Progress Note dated Ex Order 26. 4B1 for a Ex Order 26. 4B1 [redacted].

A review of the Physician's Progress Notes located in the resident's paper medical chart, included Physician's Progress Notes for Ex Order 26. dated Ex Order 26. 4B1 [redacted]. There were no documented Physician's Progress Notes after Ex Order 26. 4B1 [redacted].

On 7/27/22 at 10:17 AM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) who stated that Resident #55's Physician came to the facility twice a week and documented on the residents' paper charts that he saw the resident during his visits. The LPN/UM stated that the Physician saw all of his residents and did not have a nurse practitioner who alternated with monthly visits. If a nurse practitioner had to see one the the Physician's residents, they would call the Physician to let him know and then documented a progress note in the electronic medical record.

On 7/27/22 at 10:18 AM, the surveyor interviewed the Unit Clerk who stated that she thinned (removed documents from the paper chart to store in medical records off the unit) the residents' charts but kept the past six months of documents in the paper chart on the unit.

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F 712	Continued From page 50 On 7/27/22 at 11:37 AM, the surveyor interviewed the resident's Physician via telephone who stated that he was at the facility a minimum of three to four times a week to see his long-term care and sub-acute residents. The Physician stated that he saw all his long-term care residents at least once a month and documented on the paper medical record. The Physician stated that Resident #55 was a[redacted]. The Physician stated that the resident could[redacted] due to a[redacted] and just shakes his/her head when[redacted] to you. The Physician stated that the resident was[redacted] but was[redacted] to everyone. The Physician stated that he saw the resident monthly and there should be documentation on the chart. The Physician stated that he saw the resident in the hallway a few weeks ago picking their nose. The Physician stated if there was no documentation in the chart, then maybe the documentation was in another resident's chart. The Physician acknowledged that Resident #55's Progress Notes should not be in another resident's chart. On 7/27/22 at 12:00 PM, the surveyor interviewed the Director of Nursing (DON) who stated that she could not speak to how often the physicians had to see their long-term care residents. The DON stated that the residents' charts were thinned by the unit clerks, and one year of Physician's Progress Notes should remain on the paper charts. The DON confirmed that Resident #55's Physician only documented in the paper medical record. At this time, the surveyor and the DON reviewed Resident #55's paper medical record, and the DON confirmed that the last Physician's Progress Note was dated[redacted].	F 712		

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F 712	Continued From page 51 On 7/28/22 at 10:51 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Director of Nursing (ADON), and survey team, confirmed that the Physician had not seen Resident #55 since *Ex Order 26. 4B1*. The DON stated that long-term care residents should be seen at least every thirty days. A review of the the facility's "Physician Visits" policy dated revised February 2022, included the Attending Physician will visit residents in a timely fashion, consistent with applicable state and federal requirements...a physician visit is considered timely if it occurs no later than ten (10) days after the date the visit is required... NJAC 8:39-23.2(d)	F 712		
F 836 SS=E	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set	F 836		8/26/22

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F 836	Continued From page 52 forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) ensure a resident who required two-person assistance for positioning during Ex Order 26. 4B1 care was assisted by two people which resulted in a [redacted] with Ex Order 26. 4B1 for 1 of 2 resident (Resident #11) reviewed for [redacted] and b.) maintain required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey for 22 of 28 day shifts and 6 of 28 night shifts reviewed. The deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112,	F 836	F836(E) How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Certified Nursing Assistant(CNA) was in-serviced , and competency completed for position on Ex Order 26. 4B1 care by two people for resident #11. The leadership team of the facility continues to meet to identify staff challenges in areas of improvement for certified nursing assistant needs. How the facility will identify other residents having the potential to be affected by the same deficient practice. Any residents in the facility have the	

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F 836	Continued From page 53 codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. On 7/20/22 at 12:24 PM, the surveyor observed Resident #11 sitting up in a Ex Order 26. 4B1 [redacted] wearing a Ex Order 26. 4B1 gown, the resident appeared morbidly obese. The resident stated he/she had a [redacted]l in the facility a few months ago when Certified Nursing Aide (CNA #1) attempted to change his/her Ex Order 26. 4B1 . The resident stated they had told CNA #1 she could not do it on her own and needed another CNA to assist, but CNA #1 went ahead on her own and she subsequently dropped him/her. The resident stated he/she spent weeks in the Ex Order 26. 4B1 and had injured both Ex Order 26. 4B1 . The surveyor reviewed the medical record for Resident #11.	F 836	potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. All certified nursing assistants were in-serviced regarding following the plan of care in the Ex Order 26. 4B1 for residents requiring 2 person assist with residents plan of care for positioning during Ex Order 26. 4B1 care. Any resident requiring tow person assistance for positioning during Ex Order 26. 4B1 will be added to daily CNA assignments. The facility continues to post open positions. The facility implemented an incentive program for new hires , referrals and sign on bonuses. The facility has implemented an above market rate for our certified nursing assistant in order to maintain and recruit new staff. How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. DON or designee will meet with staffing coordinator to review staffing needs , census , and callouts weekly x 4weeks, monthly x 3 months and quarterly x 3 months. The DON or designee will continue to review the census until staffing ratio requirements are met weekly x 4 weeks, monthly x 3 weeks and quarterly x 3 months. The DON or designee will audit report findings to the Administrator and Quality Assurance Performance improvement committee, weekly x 4	

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F 836	Continued From page 54 A review of the Admission Record face sheet reflected Resident #11 was re-admitted to the facility in Ex Order 26. 4B1 with diagnoses that included a Ex Order 26. 4B1 [redacted]. A review of the most recent annual Minimum Data Set (MDS), an assessment tool dated Ex Order 26. 4B1, reflected a brief interview for mental status (BIMS) score of Ex Order 26. 4B1, which indicated a Ex Order 26. 4B1. A review of the quarterly MDS dated Ex Order 26. 4B1 included in Ex Order 26. 4B1, that the resident required for Ex Order 26. 4B1 extensive assistance of two-person assistance for Ex Order 26. 4B1 which included how the resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture. On 7/27/22 at 10:33 AM, the surveyor interviewed CNA #1 who was assigned to Resident #11 on Ex Order 26. 4B1 Ex Order 26. 4B1 who stated after washing the front of the resident she needed to turn the resident over, so she pulled the sheet that was under the Resident #11 and crossed their Ex Order 2. CNA #1 stated she had Ex Order 26. 4B1 on the resident holding them and the other hand she held a washcloth, when Resident #11's Ex Order 26. 4B1 had begun to Ex Order off the Ex Order 2, she immediately grabbed the Ex Order 2 controller and lowered the Ex Order 2 to the floor, because she knew she could not hold	F 836	weeks , monthly x 3 months quarterly x 3 months.	

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F 836	Continued From page 55	F 836		

the resident's weight. Once the [redacted] was lowered, CNA #1 eased the resident down to the floor and onto their [redacted]. The surveyor asked CNA #1 how many CNAs were working during the day shift, and CNA #1 responded there were only four CNAs because if there was a fifth CNA, she would not have been assigned to Resident #11.

On 7/27/22 at 12:15 PM, the surveyor reviewed the Daily Assignment Sheet provided by the Assistant Director of Nursing (ADON) which reflected on [redacted] the 7:00 AM - 3:00 PM shift had four CNAs assigned to the 54 residents on the third floor, which would be one CNA to every thirteen residents.

On 7/27/22 at 12:20 PM, the surveyor interviewed the Director of Nursing (DON) who confirmed prior to Resident #11's [redacted] with [redacted], the resident required extensive assistance of two-person to reposition them in [redacted]. The DON confirmed CNA #1 should not have repositioned Resident #11 on [redacted] by [redacted] and needed assistance of another person.

On 7/27/22 at 12:43 PM, the surveyor interviewed the DON who stated the amount of CNAs scheduled depended on the census on the floor. When asked how the facility determined that number, the DON replied that the facility used the New Jersey Department of Health (NJDOH) ratio that needed to be followed. The DON stated the facility did not use Agency staff, but if there were not enough CNAs, nurses could assist in patient care. At this time, the surveyor requested the facility's staffing from 1/2/22 through 1/15/22.

As per the "Nurse Staffing Report" completed by the facility for the weeks of 1/2/22 to 1/8/22 and

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F 836	Continued From page 56 1/9/22 to 1/15/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: 1/2/22 had 9 CNAs for 105 residents on the day shift, required 13 CNAs. (11.66 residents per CNA) 1/3/22 had 9 CNAs for 99 residents on the day shift, required 12 CNAs. (11 residents per CNA) 1/4/22 had 10 CNAs for 99 residents on the day shift, required 12 CNAs. (9.90 residents per CNA) 1/7/22 had 10 CNAs for 107 residents on the day shift, required 13 CNAs. (10.70 residents per CNA) 1/8/22 had 7 CNAs for 107 residents on the day shift, required 13 CNAs. (15.28 residents per CNA) 1/9/22 had 7 CNAs for 107 residents on the day shift, required 13 CNAs. (15.28 residents per CNA) 1/10/22 had 11 CNAs for 112 residents on the day shift, required 14 CNAs. (10.18 residents per CNA) 1/11/22 had 12 CNAs for 110 residents on the day shift, required 14 CNAs. (9.16 residents per CNA) 1/14/22 had 10 CNAs for 106 residents on the day shift, required 13 CNAs. (10.60 residents per CNA) 1/15/22 had 8 CNAs for 106 residents on the day shift, required 13 CNAs. (13.25 residents per CNA) On 7/28/22 at 10:19 AM, the DON in the presence of the Licensed Nursing Home Administrator (LNHA), ADON, and survey team acknowledged that a resident who was a two-person assistance could not be assisted with only one person. The DON stated that the facility	F 836		

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(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 836	Continued From page 57 had no additional staffing policies except their emergency staffing policy. At this time, the ADON stated that the facility did not have a policy regarding [redacted] care. Refer F689 2. During entrance conference on 7/19/22 at 10:32 AM, the DON in the presence of the LNHA, informed the surveyor that the facility staffing was okay. The DON stated that the facility had new hires and was continuing to hire positions. The DON stated that the facility did not use Agency staff, that if the facility was short staffed, they used their own staff by offering overtime and bonuses. As per the "Nurse Staffing Report" completed by the facility for the weeks of 7/3/22 to 7/9/22 and 7/10/22 to 7/16/22, the staffing to resident ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift; 1 direct care staff to every 10 residents for the evening shift; and no fewer then half of all staff members are CNAs during the evening shift as documented below: 7/3/22 had 6 CNAs for 95 residents on the day shift, required 12 CNAs. (15.83 residents per CNA) 7/3/22 had 5 CNAs to 13 total staff on the evening shift, required 6 CNAs. 7/4/22 had 8 CNAs for 95 residents on the day shift, required 12 CNAs. (11.87 residents per CNA) 7/5/22 had 10 CNAs for 95 residents on the day shift, required 12 CNAs. (9.50 residents per CNA) 7/5/22 had 4 CNAs to 11 total staff on the evening shift, required 5 CNAs.	F 836		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET HACKENSACK, NJ 07601**

(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 836	Continued From page 58 7/6/22 had 10 CNAs for 95 residents on the day shift, required 12 CNAs. (9.50 residents per CNA) 7/7/22 had 10 CNAs for 98 residents on the day shift, required 12 CNAs. (9.80 residents per CNA) 7/8/22 had 9 CNAs for 98 residents on the day shift, required 12 CNAs. (10.88 residents per CNA) 7/8/22 had 9 total staff for 98 residents on the evening shift, required 10 total staff. 7/9/22 had 8 CNAs for 96 residents on the day shift, required 12 CNAs. (12 residents per CNA) 7/9/22 had 5 CNAs to 13 total staff on the evening shift, required 6 CNAs. 7/10/22 had 8 CNAs for 96 residents on the day shift, required 12 CNAs. (12 residents per CNA) 7/11/22 had 7 CNAs for 96 residents on the day shift, required 12 CNAs. (13.71 residents per CNA) 7/12/22 had 10 CNAs for 96 residents on the day shift, required 12 CNAs. (9.60 residents per CNA) 7/13/22 had 9 CNAs for 96 residents on the day shift, required 12 CNAs. (10.66 residents per CNA) 7/15/22 had 5 CNAs to 12 total staff on the evening shift, required 6 CNAs. 7/16/22 had 6 CNAs for 95 residents on the day shift, required 12 CNAs. (15.83 residents per CNA) 7/16/22 had 5 CNAs to 13 total staff on the evening shift, required 6 CNAs. A review of the facility's "Identifying Neglect" policy dated 2/10/22, included preventing resident neglect is a priority throughout all levels of this organization.. Ex Order 20. 4B1 is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical pain, mental anguish, or emotional distress; any situation in which the	F 836		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET HACKENSACK, NJ 07601**

(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 836	Continued From page 59 resident's care needs are known (or should be known) by staff (based on assessment and care planning), and those needs are not met due to other circumstances, can be defined as neglect; circumstances that lead to neglect: ...lack of sufficient staffing... NJAC 8:39-5.1(a)	F 836		

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	060205	A. BUILDING: _____ B. WING _____	08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	301 UNION STREET HACKENSACK, NJ 07601

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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		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Part A Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that the Infection Preventionist who was assigned to oversee their infection control program had no other responsibilities as mandated by the State of New Jersey. This deficient practice was identified, and the findings were as followed: Reference: New Jersey Executive Directive 20-026 "Directive for the Resumption of Services	S 560	S560 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The leadership team of the facility has met to identify the need and area of improvement for Infection Control (IP) Nurse. How the facility will identify other residents	8/26/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060205	A. BUILDING: _____ B. WING _____	08/03/2022

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S 560	Continued From page 1 in all Long-Term Care Facilities" dated 1/6/21, directs the following: "iv: Facilities with no Ventilator Beds a. Facilities with 100 beds or more beds or on-site hemodialysis services must: 1.) Hire a full-time employee in the infection prevention role, with no other responsibilities and must attest to hiring no later than August 10, 2021." (*extended to February 1, 2022) On 7/19/22 at 10:32 AM, the surveyor conducted an entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor asked who was responsoible for the facility's infection control and prevention program, and the DON stated the Assistant Director of Nursing (ADON) was the facility's Infection Preventionist (IP). The DON stated that the ADON/IP did not have a certification in infection control so she oversaw the ADON/IP. The DON stated that the previous IP had left the facility sometime during the COVID-19 outbreak that started in March of 2020. On 7/26/22 at 9:42 AM, the surveyor interviewed the ADON/IP who stated that she became the IP at the end of 2020 or the beginning of 2021 after she was promoted to the ADON position. The ADON/IP stated that this was her first time as the role of the infection preventionist so she was learning as she went. The ADON/IP confirmed she had no formal infection control education, but the plan was for her to receive education. On 7/28/22 at 12:25 PM, the LNHA and DON confirmed that the facility did not have one full-time Infection Preventionist with no other job	S 560	having the potential to be affected by the same deficient practice. Any residents has the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The leadership team will recruit for the position of full -time IP Nurse with no other job duties. The leadership team will ensure the IP nurse is qualified an certified in Infection Control (CIC) by the National Board of Infection Control. Register Nurse is registered for IP class. How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. The Administrator/DON will review and continue to ensure the facility has full-time qualified and certified infection control nurse in the facility. Director of Nursing or designee will review and report findings to the Administrator and Quality Assurance performance improvement committee quarterly.	

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S 560	Continued From page 2 duties. A review of the facility's "Infection Control Nurse Job Description" included for minimum position qualification: education graduate of an approved RN [registered nurse] school of nursing with professional experience of two years of direct care nursing experience; one year of experience in a role that included infection control surveillance, trending and monitoring is preferred; and experience in a supervisory role within the nursing profession is preferred.... The job descripton also included for essential duties and reponsibilities were to: organizing, coordinating and evaluating the facility's Infection Control Program; ensures completion of all documentation necessary for evaluating the process of infection control within the facility; ensures facility maintains compliance with company infection control policies, procedures and protocols and that they are consistent with CDC guidelines..... A review of the facility's Assistant Director of Nursing job description included for position summary thet the Assistant Director of nursing was responsible for the day to day coordination and oversight of all aspects of the nUrsing Department in accordance with current Federal and State regulations as well as local regulations as assigned by the Director of Nursing. Daily responsibilities included to: attend daily report; lead nursing unit managers in resolving identified resident care and service issues and concerns and completing all required responsibilities of the position; conduct nursing unit rounds at least twice daily during tour duty; ensure resolution to any and all identified resident care or enviromental issues; ensure adquate staffing is maintained...	S 560		

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S 560	Continued From page 3 Part B Based on interview and review of pertinent facility documentation, it was determined that the facility failed to ensure that the Infection Preventionist who was assigned to oversee their infection prevention and control program met the minimum qualifications as mandated by the State of New Jersey. This was deficient practice was identified and the findings are as followed: Reference: New Jersey Executive Directive 20-026 "Directive for the Resumption of Services in all Long-Term Care Facilities" dated 1/6/21, directs the following: "In addition to the requirements in N.J.A.C. 8:39-20, the following practices shall remain in place even as LTCF's (Long-Term Care Facilities) resume normal activities, regardless of the facility's current reopening phase; ... ii. All facilities except for facilities with ventilator-dependent residents, are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; b. A physician who has completed and infectious disease fellowship;	S 560		

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S 560	Continued From page 4 c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of infection control experience." Reference: N.J.A.C 8:39 - Standards for Licensure of Long-Term Care Facilities Subchapter 20. Advisory Infection Control and Sanitation 8:39-20.2 Advisory staff qualifications dated 11/17: "a. The infection control coordinator is certified in Infection Control (CIC) by the National Board of Infection Control.... b. The infection control coordinator is an active member of the National Association for Professionals in Infection Control and Epidemiology, Inc. (APIC).... c. The infection coordinator has completed an APIC Basic Training Course or has received at least 25 hours of training in infection control, and receives additional six hours of training annually." On 7/19/22 at 10:32 AM, the surveyor conducted an entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The surveyor asked who was responsoible for the facility's infection control and prevention program, and the DON stated the Assistant Director of Nursing (ADON) was the facility's Infection Preventionist (IP). The DON stated that the ADON/IP did not have a certification in infection control so she oversaw the ADON/IP. The DON stated that the previous IP had left the facility sometime during the COVID-19 outbreak that started in March of 2020. At this time, the surveyor requested a copy the the DON's infection control certification.	S 560		

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S 560	Continued From page 5 On 7/21/22 at 9:00 AM, the surveyor reviewed the DON's infection control certification provided which was the Centers for Disease Control and Prevention (CDC) "Nursing Home Infection Preventionist Training Course" dated 7/31/2020 for 19.3 contact hours. On 7/26/22 at 9:42 AM, the surveyor interviewed the ADON/IP who stated that she became the IP at the end of 2020 or the beginning of 2021 after she was promoted to the ADON position. The ADON/IP stated that this was her first time as the role of the infection preventionist so she was learning as she went. The ADON/IP confirmed she had no formal infection control education, but the plan was for her to receive education. On 7/26/22 at 9:53 AM, the surevyor interviewed the DON who confirmed that the ADON/IP was facility's IP and she oversaw her. The DON confirmed that the 19.3 contact hour CDC Nursing Home Preventionist Training Course was her only infection control certification and that she had no additional education hours. The DON stated that she could not speak to why the ADON/IP had no infection control education, that the facility's Coorporation scheduled the training. A review of the ADON's current resume provided did not include five years or more experience in infection control. On 7/28/22 at 12:25 PM, the LNHA and DON confirmed that the facility did not have one full-time Infection Preventionist with no other job duties. The LNHA also acknowledged that the ADON/IP had no infection control education. When the surveyor asked why the ADON/IP had received no training, the LNHA responded that the ADON/IP did not want the role as the IP so	S 560		

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S 560	Continued From page 6 she was never trained. NJAC 8:39-5.1(a)	S 560		
S2115	8:39-31.1(b) Mandatory Physical Environment b) New construction, alterations and additions of long-term care facilities shall comply with the Uniform Construction Code (N.J.A.C. 5:23) as adopted by the New Jersey Department of Community Affairs. The New Jersey Uniform Construction Code may be obtained from the Construction Code Element of the Department of Community Affairs, P.O. Box 805, Trenton, New Jersey 08625-0805. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and documentation review on 8/2/22 in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to ensure that areas under renovation were not occupied prior to receiving the certificate of occupancy and the notification to the New Jersey Department of Health (NJDOH). This deficient practice was evidenced by the following:	S2115	S2115 How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were directly affected. Appropriate permits and inspections have been obtained. How the facility will identify other residents	8/26/22

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S2115	Continued From page 7 In an interview on 8/2/22 at 10:30 AM, the facility's Maintenance Director and Regional Plant Operations Director stated that there were renovations/construction to resident rooms. At 11:30 AM. the surveyor observed resident rooms that were completed and were now occupied with residnets: Room 301 had one resident; Rooms 303, 304, 305, 306, 307, and 308 each had two residents occupying it, and Room 309 had one resident in it. The Maintenance Director and Regional Plant Operations Director stated at that time that the township did not issue a Certificate of Occupancy to allow the use of these areas and stated that they were unaware that the rooms required notification to anyone prior to occupancy. The facility provided the surveyor a copy of a city permit for the proposed work being done and was authorized for building, plumbing and electrical dated 3/25/2019, but there was no certificate of occupancy provided. The permit document stated at the bottom that, "This notice shall be posted conspicuously at the work site and shall remain so until issuance of a certificate" but the facility never received a certificate from the city to close out the permits. They also were not able to provide any proof from the city that they informed them that the work was complete and ready for an inspection. A review of the Final Release of the project from The NJ Department of Community Affairs, dated 06/18/18 stated "At the completion of the project and prior to occupying the area or areas, "it has been determined that the local review of this project is appropriate." Prior to occupying the project area, a copy of the "CERTIFICATE OF OCCUPANCY" must be provided to the New	S2115	having the potential to be affected by the same deficient practice. All residents in the center have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The contractor company was educated to obtain all necessary paperwork by the local Hackensack building inspector. The facility will ensure certificate permit of occupancy is provided by the city and posted conspicuously at the work site prior to occupying the area (s). How the facility will monitor monitor its corrective action to ensure that the deficient practice will not recur. The facility management will maintain close interaction with local building inspector department to ensure compliance will all inspections and permits. The facility will audit for permits to ensure compliance. Administrator or designee will forward the results of the audit to Quality Assurance Performance Improvement (QAPI)Committee quarterly.	

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S2115	Continued From page 8 Jersey Department of Health Assessment & Survey Unit. A review of the NJDOH letter issued to the facility on 8/21/2018 indicated that "in accordance with NJAC 8:39-2.4, 'the facility shall contact the Department's Certificate of Need and Healthcare Facility Licensure Program for inspection and/or licensure upon completion of the project and prior to occupying the space.'" On 8/2/22, the facility administration was unable to provide documented evidence that this was done prior to occupying the renovated space.	S2115		

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{F 000}	INITIAL COMMENTS Revisit Date: 10/11/22 SAMPLE SIZE: 3 An Onsite Revisit 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 689} SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a.) provide a clutter free environment, and b.) develop and implement a care plan to prevent [redacted] for a resident with a history of multiple [redacted]. This deficient practice was identified for 1 of 3 residents reviewed for accidents (Resident #2) who had 4 [redacted] over a period of 11 days. The evidence was as follows: A review of the plan of correction (POC) for Element Three - Systemic changes, indicated that staff were re-educated regarding following the plan of care in the Kardex for all residents including those requiring two-person assist.	{F 689}	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice: A) Certified Nursing Assistant (CNA) was educated regarding following resident plan of care, for resident #2. B) Nurses were educated on updating care plans timely at the time of an [redacted] to minimize the risk of further [redacted] How the facility will identify other residents having the potential to be affected by the same deficient practice: Any resident in the facility has the	11/1/22

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

Electronically Signed | 11/09/2022

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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET HACKENSACK, NJ 07601**

(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 689}	Continued From page 1 A review of Element Four of the POC - Monitoring, indicated the Director of Nursing (DON) and Assistant Director of Nursing (ADON) or designee will monitor and perform surveillance to ensure that the Certified Nursing Aides (CNAs) are following the plan of care for patients. The facility alleged completion for their POC was 8/25/22. On 10/6/22 at 1:05 PM, the surveyor observed Resident #2 in Ex Order with his/her eyes closed and appeared to be sleeping. Surrounding the resident's Ex Order was a dresser that was moved to be pressed up against the Ex Order 26. 4B1 of the resident's Ex Order frame and a bedside table positioned at Ex Order 26. 4B1 of the Ex Order. On the Ex Order 26. 4B1 of the resident's Ex Order was a standard chair that was pressed up against the Ex Order frame and an unlocked Ex Order 26. 4B1 on the Ex Order 26. 4B1 end of the Ex Order by the resident's feet. The surveyor observed that there were pieces of furniture or equipment positioned surrounding all four areas of the resident's Ex Order while the resident was lying in it. In addition, the resident had both half siderails in the up position at the head of the Ex Order 26 There were no floor mats observed on either side of the resident's Ex Order. The surveyor attempted to interview the resident who was Ex.Order 26 but did not respond when addressed. The resident could not tell the surveyor who put the furniture and other equipment around the Ex Order. The surveyor reviewed the medical record for Resident #2. A review of the Admission Record face sheet (an admission summary) reflected the resident was	{F 689}	potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur? A) All Certified Nursing Assistants were in-serviced regarding following the plan of care for resident and providing a clutter-free environment for the residents. B) Staff will perform frequent rounding to ensure that environment will be free from clutter. C) The IDCP (Interdisciplinary Care Planning) team will meet to discuss all Ex Order 26. 4B1 and review the care plan interventions that reflect the Ex Order 26. 4B1. How the facility will monitor its corrective action to ensure that the deficient practice will not recur: A) DON (Director of Nursing) or designee will perform environmental round, weekly x 4 weeks; then monthly x 3 months. B) DON (Director of Nursing) or designee will audit the care plan interventions that reflect the incident, weekly x 4 weeks, then monthly x 3 months. C) DON (Director of Nursing) or designee will report findings to the QAPI (Quality Assurance Performance Improvement) committee quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING _____ B. WING _____	R 10/11/2022

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CAREONE AT WELLINGTON	**301 UNION STREET HACKENSACK, NJ 07601**

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{F 689}	Continued From page 2 admitted to the facility with diagnoses that included Ex Order 26. 4B1 [redacted] A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated Ex Order 26. 4B1, reflected that the resident had a Brief Interview for Mental Status (BIMS) score of Ex Order 26. 4B1, which indicated a Ex Order 26. 4B1 [redacted]. A review of "Section G, Functional Status" reflected the resident was an extensive Ex.Order 26.4(b)(1) for Ex Order 26. 4B1 and for Ex Order 26. 4B1 [redacted] and the resident was identified as Ex.Order 26.4(b)(1) [redacted] It further included that the resident had two or more Ex Order 2 with Ex.Order 26.4(b that is not Ex.Order 26.4(b)(1) and one Ex Orde Ex.Order 26.4(b)(1) since admission to the facility. A review of the Ex Order Risk Evaluation dated 9/9/22, reflected the resident was assessed to be at Ex Order 2 [redacted] due to Ex.Order 26.4(b)(1) [redacted] that can Ex Order 26. 4B1 a person to Ex Order 2, and had three or more Ex Order 26. 4B1 [redacted] that put the resident at greater risk for Ex Order 2. The Ex Orde risk assessment did not incorporate recommendations for interventions for inclusion into the care plan, as a result of scoring a Ex Order 26. 4B1 on the risk assessment. A review of the individualized care plan initiated as early as Ex Order 26. 4B1 revealed that there was no care plan to address the resident's risk for Ex Order 2 until 11 days after the Ex Orde risk assessment which revealed that the resident was at Ex.Order 26.4(b)(1) for	{F 689}		

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{F 689}		{F 689}		

Continued From page 3

[redacted]. The care plan for [redacted] was not initiated until [redacted].

The care plan that was not initiated until [redacted], included the resident was at [redacted], due to a history of [redacted], [redacted], with four actual [redacted] noted on [redacted]. The care plan included an intervention for [redacted] on [redacted], which was after the resident's fourth [redacted] at the facility.

On 10/6/22 at approximately 1:05 PM, the surveyor attempted to get the resident's assigned Certified Nursing Aide (CNA) for an interview regarding how the surveyor observed Resident #2.

At approximately 1:10 PM, another CNA stated that the resident's assigned CNA was on a lunch break and was not available for an interview at that time. The surveyor was unable to locate a nurse on the unit.

On 10/6/22 at 1:45 PM, three surveyors accompanied by the DON and the Licensed Nursing Home Administrator (LHNA), as well as the assigned CNA, went to Resident #2's room and observed the resident in [redacted] with his/her eyes closed and the resident still had the furniture and equipment pressed up against the [redacted] as seen at 1:05 PM, with a dresser and bedside table to the [redacted] of the [redacted] and a standard chair and unlocked [redacted] to the [redacted] of the [redacted]. The siderails were up at the head of the [redacted]. There were no floor mats observed on either side of the [redacted]. The DON stated, [redacted] The surveyors asked if this

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{F 689}	Continued From page 4	{F 689}		

was acceptable and the LNHA replied, "Absolutely not. This is not the normal setup."

At this time, the surveyor interviewed the resident's assigned CNA who stated he performed Ex Order 26. 4B1 and moved the resident to the nurses' station common area. The CNA stated he observed Resident #2 in their Ex Order 26. 4B1 falling asleep at the nurses' station prior to going on a lunch break. The CNA continued he could not find any staff at the nurse's station to cover his shift while he went on a lunch break, so he returned the resident to Ex Order and arranged the furniture around the Ex Order to prevent the resident from Ex Order 26. 4B out of Ex Order. The CNA stated, "Someone was supposed to cover for me today during lunch, but nobody was around." The CNA stated he normally would not move the furniture around the Ex Order, but he could not find another CNA prior to going on his lunch break. The CNA stated the resident was able to move the chair and Ex Order 26. 4B1 to sit up in Ex Order and Ex Order 26. 4B1 to the Ex Order 26. 4B1. The CNA stated Ex Ord does not follow a care plan for the resident, and he was unaware the resident was supposed to have Ex Order 26. 4B1 Ex.Order 26.4(b)(1) on either side of the Ex Order. The CNA stated there were no Ex.Order 26.4(b)(1), and that Ex Ord had never seen Ex.Order 26.4(b)(1) in the resident's room since the resident was admitted.

10/6/22 at 3:09 PM, the surveyor asked the DON in the presence of the survey team if the resident had a care plan for Ex.Order 26.4(b)(1) and the DON replied that she had to "investigate" if the resident was supposed to have Ex.Order 26.4(b)(1)

On 10/6/22 at 3:40 PM, the surveyors (3) along with the LNHA, DON, ADON and Director of

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{F 689}	Continued From page 5	{F 689}		

Quality Assurance (DQA) observed the resident resting in [redacted] with one floor mat leaning against the wall, and not on the floor next to the [redacted]. The DON stated that the single [redacted] was found in the resident's closet and she could not speak to why the [redacted] was not in place next to the resident's [redacted] while the resident was in [redacted] or why the other [redacted] was missing. The DON also stated the resident was able to move the furniture away from his/her [redacted] in order to sit up and [redacted] to the [redacted]. At this time, the DON asked the resident to move the chair next to his/her [redacted]. The surveyors observed the resident, with much effort, move the chair slightly away from the [redacted], pull him/her-self up with the aid of the side rails and put both feet on the ground. The resident was [redacted] to [redacted] independently to the [redacted]. The ADON and the DON assisted the resident into the [redacted].

At this time, the resident stated he/she tried to get into the chair most of the time. The resident also stated he/she had to move the chair if they wanted to get out of [redacted].

The surveyor continued to review the medical record for Resident #2.

A review of the [redacted] report which are linked to the Progress Notes dated [redacted], reflected on [redacted] at 2:40 AM, the resident had a unwitnessed [redacted]. Resident #2 was found lying on his/her [redacted] next to the [redacted], alert and [redacted] The resident complained of [redacted] out 10 [redacted] and the resident was treated with [redacted]. There was no physical signs of [redacted] The investigative report included interventions to

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{F 689}	Continued From page 6	{F 689}		

be put in place as a result of this [redacted] were to report development of Ex Order 26. 4B1 [redacted] per facility guidelines. This intervention was not updated and included in the resident's care plan until [redacted].

A review of a second unwitnessed [redacted] report linked to the Progress Notes dated two days later on [redacted], reflected on [redacted] at 2:00 PM, Resident #2 was found on the floor, laying on the floor mat next to the [redacted] and a Ex Order 26. 4B1 [redacted] There were no physica [redacted]. Interventions put in place as a result of this [redacted] were to encourage resident to lock the Ex Order 26. 4B1. This intervention was not included in the resident's care plan until [redacted].

A review of a third [redacted] report linked to the Progress Notes dated two days later on [redacted], reflected on [redacted] at 2:55 PM, Resident #2 was found in a sitting position on the floor next to his/her bathroom door. Resident #2's [redacted] was against the wall and both legs extended. The resident had a [redacted] to Ex Order 26. 4B1 [redacted] that measured Ex.Order 26.4(b)(1) and [redacted] to their [redacted] and [redacted] provided. The resident denied [redacted]. Interventions put in place as a result of this [redacted] was to put Ex.Order 26.4(b)(1) to bedside, however, this was not appropriate as the [redacted] investigation from two days earlier revealed that the resident was found on Ex.Order 26.4(b)(1). Again, this intervention was not included in the resident's care plan until [redacted]

A review of the fourth [redacted] report linked to the Progress Notes dated [redacted], reflected on [redacted] at 3:10 PM, Resident #2 was found in

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{F 689}	Continued From page 7	{F 689}		

supine position on the floor with their head underneath the [redacted]. Resident was alert and responsive, and [redacted] was [redacted]. The report did not include the [redacted] were in place per the intervention added as a result of the [redacted] on [redacted]. Interventions put in place as a result of the [redacted] were patient to be in supervised area when out of [redacted]. The resident stated that he/she was reaching for the remote which led to the [redacted]. The resident denied [redacted] but an [redacted] were ordered which revealed no acute [redacted]. The investigation did not reveal why the [redacted] was "elevated" nor did the care plan address the elevated [redacted].

A review of the Active Physician's Orders dated [redacted], included a physician's order (PO) dated [redacted] for fall precautions every shift. The Active Physician's Orders did not include a floor mat at bedside.

On 10/6/22 at 4:25 PM, the surveyors (3) interviewed the LNHA and DON who acknowledged the resident did not have [redacted] on floor, the care plan did not address the interventions after each of the [redacted], and the furniture around [redacted] could pose a hazard.

A review of the facility policy, [redacted] - Clinical Protocol" dated revised March 2018 included...if underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of [redacted], until [redacted] reduces or stops or until a reason is identified for its continuation [redacted] ...Monitoring and Follow-up...the staff and physician will monitor and document the

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{F 689}	Continued From page 8 individual's response to interventions intended to reduce [Ex Order 26. 4B] or the consequences of [Ex Order 26. 4B] NJAC 8:39 27.1(a)	{F 689}		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060205	A. BUILDING: _____ B. WING _____	R 10/11/2022

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{S 000}	Initial Comments THE FACILITY WAS IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES.	{S 000}		

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

Electronically Signed | 11/09/22

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
315152 Y1	A. Building B. Wing Y2	11/22/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	301 UNION STREET HACKENSACK, NJ 07601

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 F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 11/01/2022	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
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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	
8/3/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{S 000}	Initial Comments	{S 000}		

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

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	315152	A. BUILDING **02** B. WING _____	**08/03/2022**

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E 000	Initial Comments This facility is 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		
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 8/2/22 and 8/3/22, 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 Occupancy The facility is a 3-story building that was built in 70's, It is composed of Type I fire resistant construction. The facility is divided into 6- smoke zones. The generator does 100% of the facility. The facility utilized 1135 waivers allowing for regulatory flexibilities during the Public Health Emergency for routine inspection, testing and maintenance requirements beginning January 31, 2020. The flexibilities did not extend to the following items: fire pump weekly/monthly testing, fire extinguisher monthly inspections, fire fighter operation monthly testing for elevators, monthly testing of generators, and daily inspection of the means of egress in areas of construction, repair, alterations or additions. The facility has 128 certified beds. At the time of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2022

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K 000	Continued From page 1 the survey the census was 87.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222		8/26/22

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CAREONE AT WELLINGTON	**301 UNION STREET** **HACKENSACK, NJ 07601**

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K 222	Continued From page 2 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of Maintenance Director, Plant Operations Director on 8/3/22, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6 for 1 of 2 sets of exterior exit/egress doors observed. This deficient practice was identified for 1 of 2 sets of doors and was evidenced as follows:	K 222	K222SSF What corrective action will be accomplished for those residents affected by the deficient practice? There were no patients identified who were affected by the condition. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? Patients residing in the facility have the	

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	315152	A. BUILDING **02** B. WING _____	**08/03/2022**

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K 222	Continued From page 3 At 11:08 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed two sets of glass sliding doors located at the rear of the facility, the interior set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. At the time of the observation, the surveyor interviewed the Maintenance Director and Regional Plant Operations Director who stated that the lockset (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency. The Licensed Nursing Home Administrator was notified of the findings at the Life Safety Code Exit Conference on 8/3/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	potential to be affected. What measures will be put into place, or what systematic changes will you make to ensure that the deficient practice will not reoccur? The lock set that was removed from the sliding glass door, disabling the deadbolt allowing unrestricted entrance/exit. Maintenance staff will be in-serviced on that exit doors, in the means of egress should be readily accessible and free of all obstructions or impediments for instance use in the case of fire or other emergencies. How will the corrective be monitored to ensure the deficient practice will not reoccur, i.e., what quality assurance program will be put into place? The maintenance director or designee will monitor and audit the exit doors weekly for four weeks, then monthly for two months to ensure all exits are unrestricted and accessible for emergency use. The findings will be presented to the QAPI committee and the administrator. The QAPI committee who meet monthly will determine the need for further performance improvement.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		8/26/22

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K 321	Continued From page 4 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/3/22, in the presence of the Maintenance Director and Regional Plant Operations Director, it was determined that the facility failed to provide and maintain self-closing device on doors to hazardous area in accordance with NFPA 101, 2012 Edition, Section 19.3.2.1, 19.3.2.1.3, 19.3.2.1.5, 19.3.6.3.5, 19.3.6.4, 8.3, 8.3.5.1, 8.4, 8.5.6.2 and 8.7. This deficient practice was	K 321	K321(E) What corrective action will be accomplished for those residents affected by the deficient practice? There were no patients identified who were affected by this condition. How will you identify other residents having the potential to be affected by the	

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K 321	Continued From page 5 identified in 1 of 10 hazardous storage areas in the facility and was evidenced by the following: At 12:10 PM, the surveyor, Maintenance Director and Regional Plant Operations Director observed Resident Room #315 was now being used to store construction material. The room was more than 50 square feet in size and contained combustible boxes, paper bags, ceiling tiles, shop vacuum, clear plastic sheet, spackle bucket and a gray plastic garbage container. The door to the room did not have an auto-closing device installed. At the time of the observation, the surveyor interviewed the Maintenance Director who confirmed that hazardous storage areas must have a door with a self-closing device. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code Exit Conference on 8/3/22. NJAC 8:39-31.2(e)	K 321	same deficient practice, and what corrective action will be taken? Patients residing in the facility have the potential to be affected. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice will not recur? An auto-closing device was installed in resident room 315. Maintenance staff will be in-serviced that all hazardous storage areas should have automatic self-closing devices on each door. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director or designee will monitor and audit all doors in hazardous areas for two times weekly for two months and then monthly for four months to ensure all doors to hazardous areas have self-closing devices. The findings will be presented to the QAPI committe which meet monthly and the administrator. The QAPI committee will determine the need for further performance improvement. Audits are conducted weekly to ensure all hazardous areas are locked and secure. This will be done weekly for 3 months.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		8/26/22

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K 345	Continued From page 6 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 observation and interview on 8/2/22, it was determined that the facility failed to ensure that their building's fire alarm system was maintained in accordance with the requirements of NFPA 70 and 72. This deficient practice had the potential to affect all residents in the facility and was evidenced by the findings below: On 8/2/22 at approximately 9:40 AM, in the presence of the facility's Maintenance Director and Regional Plant Operations Director, the surveyor observed that the fire alarm annunciator panel indicated, "Trouble." The surveyor observed that the amber trouble light was activated in 3 of 3 panels observed. The Maintenance Director provided a document from the facility vendor dated 7/21/22 which indicated that 2-troubles on arrival and departure (negative ground fault and city tie trouble); the facility's vendor disconnected all of the field wiring from the panel and the ground did not clear. They also detected a ground on the connected to the auxiliary [aux] normally open contacts. The panel is a Simplex 4010; the vendor recommends replacing the panel that has an internal ground, then troubleshoot the ground on the aux contacts.	K 345	K345 (F) What corrective action will be accomplished for those residents affected by the deficient practice? There are no patients identified who were affected by the issue. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? Patients residing in the center have the potential to be affected. What measures will be put into place or what systematic changes will you put into place to ensure the deficient practice will not recur? Facility maintenance director ordered the main board for the fire alarm panel, as the parts to repair are obsolete. Maintenance staff will be in-serviced to monitor panel until replacement arrives from vendor. A new fire alarm panel is required; the Time Limited Waiver Request was	

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K 345	Continued From page 7 At this time, the surveyor interviewed the Maintenance Director and Regional Plant Operations Director who stated that the trouble issue with the fire alarm annunciator panels was a problem with a ground wire from a recent storm. Maintenance Director stated that the fire alarm system currently operated normally, but the grounding issue remained. NFPA 9.6.1.5* To ensure operational integrity, the fire alarm system shall have an approved maintenance and testing program complying with the applicable requirements of NFPA 70,National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. The Licensed Nursing Home Administrator was informed of the deficiency at the Life Safety Code Exit Conference on 8/3/22. NFPA 70 NFPA 72 NJAC 8:39-31.2(e)	K 345	submitted because the vendor has informed us that supply chain issues are delaying the ability to obtain the parts needed to complete the repair. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? The maintenance director or designee will monitor the fire alarm panel seven times weekly until panel is replaced and will continue after it is replaced. Findings will be presented to the QAPI committee, which meets monthly, and the administrator. The QAPI committee will determine the need for further performance improvement.	
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	K 353		11/7/22

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K 353	Continued From page 8 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 and interview on 8/2/22, it was determined that the facility failed to a.) maintain the sprinkler system by ensuring that the ceiling was smoke resistant and fire rated in accordance with NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1. and b.) maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. This deficient practice was determined by the following: 1. On 8/2/22 at 10:48 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed in the basement/ground floor (construction closet) that 4-oversized ceiling tile cuts around wires and pipes. This would allow for the passage of heat and smoke into the space above which would delay the activation of the fire sprinkler system and smoke detectors. 2. On 8/2/22 at 10:55 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed in the basement/ground floor (communication closet)	K 353	K353(F) What corrective action will be accomplished for those residents affected by the deficient practice? There were no patients identified who were affected by the condition. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective actions will be taken? Patients residing in the center have the potential to be affected. What measures will be put into place or what systematic changes will be made to ensure the deficient practice will not recur? All ceiling tiles were replaced that were affected to ensure ceilings are smoke resistant and fire rated. Maintenance director arranged for hydrostatic testing for the fire department connection with the sprinkler system. The hydrostatic test was completed on November 7, 2022.	

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K 353	Continued From page 9 that an approximately two-inches by two-inches (2" x 2") opening in the ceiling. This would allow for the passage of heat and smoke into the space above which would delay the activation of the fire sprinkler system and smoke detectors. 3. On 8/2/22 at 11:10 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed 4-oversized ceiling tile openings, in the basement/ground floor (Chapel Closet). This would allow for the passage of heat and smoke into the space above which would delay the activation of the fire sprinkler system and smoke detectors. 4. On 8/2/22 at 11:34 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed 15-oversized drop ceiling tile openings around pipe and wiring in the basement electrical room. This would allow for the passage of heat and smoke into the space above which would delay the activation of the fire sprinkler system and smoke detectors. 5. On 8/2/22 at 11:45 AM, the surveyor, Maintenance Director and Regional Plant Operations Director observed during the fire sprinkler documentation review dated 6/7/22 that no device deficiencies were observed, but under other deficiencies it was noted that the fire department connection (FDC) requires hydrostatic testing. The Maintenance Director confirmed the above findings during the building tour on 8/2/22. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code Exit Conference on 8/3/22.	K 353	What measures will be put into place or what systematic changes will be made to ensure the deficient practice will not recur? Maintenance director or designee will monitor and audit ceiling tiles weekly for four months to ensure compliance. Findings will be presented to QAPI committee, which meets monthly, and administrator. QAPI committee will determine the need for further performance improvement. Maintenance director or designee will ensure hydrostatic testing is completed within regulatory guidelines and monitored annually. Report will be sent to the administrator and QAPI committee	

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K 353	Continued From page 10 NJAC 8:39-31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, Section 6.2.7.1 and NFPA 25, 2011 Edition, Section 5.1, 5.2.2.1.	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no	K 363		8/4/22

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K 363	Continued From page 11 restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/3/22, it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring that room doors will close and latch restricts the ability of the facility to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was identified in 3 of 50 resident room doors observed and was evidenced by the following: On 8/3/22 at 9:30 AM, the surveyor, Maintenance Director, and Regional Plant Operations Director toured the facility and observed the following: Resident Room #302 the door would not latch due to a hardware issue. Resident Room #325 the door rubbed onto the floor preventing closure. Resident Room #332 the door would not latch due to a hardware issue. At the time of observations, the surveyor interviewed the Maintenance Director who	K 363	K363(E) What corrective action will be accomplished for those residents affected by the deficient practice? The resident room doors identified (302, 325, 332) will be repaired and/or replaced to fit properly in their door frames. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? Patients residing in the facility have the potential to be affected. What measures will be put into place or what systematic changes will you make to ensure the deficient practice will not recur? An audit of corridor and patient room doors was conducted to identify any doors that do not fit properly into the door frames. How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance	

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K 363	Continued From page 12 confirmed the above findings. The Licensed Nursing Home Administrator was informed of the finding at the Life Safety Code Exit Conference on 8/3/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363	program will be put into place? Director of Maintenance or designee will inspect and audit 10 doors once weekly to ensure those doors fit properly into their frames, therefore being able to resist the passage of smoke. The audit will be conducted weekly for 4 weeks and then monthly for 2 months. The findings will be presented to the administrator and QAPI committee monthly and the QAPI committee will determine the need for further performance improvement.	
K 521 SS=E	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 8/3/22, it was determined that the facility failed to ensure resident bathroom ventilation systems for 4 of 28 units were adequately maintained, in accordance with the National Fire Protection Association (NFPA) 90 A, B. This deficient practice was evidenced by the following: On 8/3/22 at 9:30 AM, the surveyor with the	K 521	K521(E) What corrective action will be accomplished for those residents affected by the deficient practice? The resident bathroom ventilation systems (313,319,323,325) will be repaired and replaced as necessary to ensure compliance. How will you identify other residents	9/13/22

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K 521	Continued From page 13 Maintenance Director and Regional Operations Director toured the facility and observed that the ventilation in the following Resident Room bathrooms did not function: #313, #319, #323 and #325. At the time of observations, the surveyor requested that the Maintenance Director confirm if the units were functioning by placing a piece of single-ply toilet tissue paper across the ceiling grills to confirm ventilation. When tested, the tissue did not hold in place. The resident bathrooms were not provided with a window and required reliance on mechanical ventilation. At that time, the surveyor interviewed the maintenance staff member and Regional Plant Operations Director, who confirmed that the exhaust vents in the above resident room bathrooms were not functioning when tested. The Licensed Nursing Home Administrator was informed of the findings at the Life Safety Code Exit Conference on 8/3/22. NFPA 90 A NFPA 101-2012 -19.5.2.1 section 9.2.2 NFPA 101-2012- 19.5.2.1 Chapter 9.1 Utilities 9.2.1 NJAC 8:39-31.2(e)	K 521	having the potential to be affected by the same deficient practice, and what corrective action will be taken? Patients residing in the facility have the potential to be affected. What measures will be put into place or what systematic changes will be made to ensure the deficient practice will not recur? An audit of bathroom ventilation systems for patient bathrooms will be conducted. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director of Maintenance or designee will inspect and audit 10 patient bathrooms weekly to ensure there is proper ventilation. The audit will be conducted weekly for 4 weeks and monthly for 2 months after. The findings will be presented to the administrator and the QAPI committee monthly. The QAPI committee will determine the need for further performance improvement.	
K 531 SS=F	Elevators CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in	K 531		8/26/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING **02** B. WING _____	**08/03/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET** **HACKENSACK, NJ 07601**

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K 531	Continued From page 14 ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review on 8/3/22, it was determined that the facility failed to ensure that elevators' firefighters service was operated monthly with a written record for 2 of 2 elevator devices, in accordance with NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3. This deficient practice was evidenced by the following: During record review with the Surveyor, Maintenance Director, and Regional Plant Operations Director on 8/3/22 at 12:50 PM, there was no documented evidence that all existing elevators; having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes conformed with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke	K 531	K531(F) What corrective action will be accomplished for those residents affected by the deficient practice? No patients were identified who were negatively affected. How will you identify other residents having the potential to be affected by the same deficient practice, and what corrective action will be taken? Patients residing in the facility have the potential to be affected. What measures will be put into place or what systematic changes will you make to ensure the deficient practice will not recur? The facility will conduct accurate testing	

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	315152	A. BUILDING **02** B. WING _____	**08/03/2022**

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K 531	Continued From page 15 detector automatic recall, firefighter's service Phase II emergency in-car key.19.5.3, 9.4.2, 9.4.3. The Regional Plant Operations Director provided a Monthly Fire Service Test Log indicating on the following dates: 1/17/22; 2/6/22; 3/15/22; 4/6/22; 5/11/22; and 6/20/22. The provided log indicated a check for pass or fail on the phase II test, but did not indicate if the tests had passed or failed. The phase I was left blank. The current document only provided an incomplete log for 1-elevator and the facility had two elevators. The findings were verified by the Maintenance Director and Regional Plant Operations Director at the time of the observations. The Licensed Nursing Home Administrator was informed of the finding at the Life Safety Code Exit Conference on 8/3/22. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section 19.5.3, 9.4.2, 9.4.3.	K 531	and complete the log for phase 2 testing. Log will be completed in full monitoring the phase 2 test and documents to be posted in elevator room as required. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? Director of Maintenance or designee will complete elevator logs to ensure compliance. The logs will be reviewed and the audit will be conducted 1x monthly for 6 months. The findings will be presented to the administrator and the QAPI committee, who meet monthly and determine the need for further improvement.	
K 918 SS=F	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.	K 918		8/26/22

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	315152	A. BUILDING **02** B. WING _____	**08/03/2022**

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K 918	Continued From page 16 Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. 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 observations, interview, and review of facility documents on 8/3/22, it was determined that the facility failed to a.) certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and b.) ensure that a remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	K918(F) What corrective action will be accomplished for those residents affected by the deficient practice? No patients were affected by this deficient practice. How will you identify other residents having the potential to be affected by the same practice and what corrective action	

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K 918	Continued From page 17 This deficient practice was evidenced for 1 of 1 generator logs provided by the Maintenance Director by the following: 1. On 8/3/22, a review of the generator records for the previous twelve months, did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently the Maintenance Director was performing a monthly load test, but he was not recording the required transfer times completely on the testing log. and the times documented (4 of 12) were over the 10-second requirement. The current monthly dates indicated : 9/30/21 load test transfer time-16-seconds 10/27/21 load test transfer time-16-seconds 3/29/22 load test transfer time-16-seconds 4/29/22 load test transfer time-16-seconds An interview was conducted with the Maintenance Director at the time of record review, who confirmed there were only 4 of 12 load test transfer times on his log, that was provided to the surveyor. 2. On 8/3/22 at 12:40 PM, the surveyor, Maintenance Director and Regional Plant Operations Director, observed that the facility exterior generator did have an exterior shutoff, but it was on the generator cabinet next to an open vent and not remote of the prime mover. An interview was conducted during the observation with the Maintenance Director. He stated that he was unaware that the manual stop station needed to be remote of the prime mover	K 918	will be taken? Patients residing in the facility have the potential to be affected. What measures will be put into place or what systematic changes will you make to ensure the deficient practice will not recur? A remote manual stop station installation date was obtained and scheduled. Compliance with monthly load test and transfer time will be completed. The generator program will be replaced to meet standards of ten second transfer. A remote manual stop station installation was completed on 8/26/2022. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director of maintenance or designee will inspect the manual stop station to ensure there is unrestricted access. Full load testing will be completed by competent personnel weekly to include a complete simulated cold start and automatic transfer of all EES (Essential Electrical System) loads. An audit will be conducted for compliance of weekly test for 6 months and findings reported to the administrator and QAPI committee, which meets monthly. The QAPI committee will determine the need for further performance improvement.	

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K 918	Continued From page 18 cabinet. The Licensed Nursing Home Administrator and Regional Operations Director were informed of the findings at the Life Safety Code Exit Conference on 8/3/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918	A TIME LIMITED WAIVER REQUEST HAS BEEN REQUESTED IN CONNECTION WITH THIS POC THIS TIME LIMITED WAIVER REQUEST WORKS WAS COMPLETED 11.10.2022	

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
315152 Y1	A. Building 02 - WELLINGTON HALL B. Wing Y2	1/18/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	301 UNION STREET HACKENSACK, NJ 07601

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 K0222	08/26/2022	LSC K0321	08/26/2022	LSC K0345	08/26/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0353	11/07/2022	LSC K0363	08/04/2022	LSC K0521	09/13/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0531	08/26/2022	LSC K0918	08/26/2022	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	
8/3/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO