STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 9/6/19 CENSUS: 81 SAMPLE SIZE: 18 + 3 =21 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Assessment (MDS) for 1 of 20 residents reviewed, Resident #70 as evidenced by the following: On 9/4/19 at 10:50 AM, the surveyor reviewed the records of Resident #70. The resident was admitted to the facility on [redacted] with diagnosis	F 637	Resident #70's plan of care was not affected. MDS updated to reflect Significant change in status. Residents who had a significant change in status had the potential to be affected. Current resident records will be reviewed in order to validate that no significant change in status MDS have been unintentionally omitted.	10/1/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/17/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

(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 637	Continued From page 1 that included [redacted]. The resident was admitted under [redacted] The surveyor reviewed the MDS assessments for Resident #70. SCSA MDS was not noted that it was completed. SCSA MDS is a federally mandated process comprehensive assessment that is required when a resident enrolls in a [redacted] program and must be completed within 14 days after the determination date to ensure that the residents will be assessed including a care plan meeting with the Interdisciplinary Team to provide the resident the best quality of care. On 9/4/19 at 11:47 AM, the surveyor spoke with the MDS Coordinator who stated that the SCSA MDS was not completed. The surveyor informed the Administrator and the Director of Nursing who did not provide any further information. NJAC 8:39-11.7	F 637	Nurse case management Department has been educated by the Regional Director of Nurse Case Management of the RAI guidelines and the requirement to complete significant change in assessment MDS's upon initiation or discontinuation of [redacted] services. [redacted] and the Unit Managers will notify Nurse Case Management Department upon initiation and/or discontinuation of [redacted] services. Center Director of Nurse Case Management to maintain a list of residents receiving hospice services. Center Director of Nurse Case Management will monitor the medical records of hospice residents weekly x 4 weeks, then monthly x 5 months to validate that MDS are complete timely, and accurate. Findings will be reported to the center QAPI committee monthly for 6 months.	
F 640 SS=D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments.	F 640		10/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

(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 640	Continued From page 2	F 640		

(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

(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 640

Continued From page 3

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set - Discharge Assessment in accordance with federal guidelines. This deficient practice was identified for 3 of 3 residents reviewed for resident assessment, Residents #1, #2, and #70.
This deficient practice was evidenced by:

1.) On 9/4/19 at 10:00 AM, the surveyor reviewed Resident #1's electronic medical record. The record revealed that the resident was admitted to the facility on [redacted] with diagnoses that included [redacted] Further review of the record revealed that the resident was discharged [redacted]

The surveyor reviewed the Minimum Data Set (MDS) 3.0 Assessment History assessment tool, including all the completed MDS's for the resident. The MDS assessment history revealed that there was no Discharge Assessment MDS completed for the resident's discharge date of [redacted]

2.) On 9/4/19 at 10:20 AM, the surveyor reviewed Resident #2's electronic medical record. The record revealed that the resident was admitted to the facility on [redacted] with diagnoses that included [redacted] Further review of the record revealed that the resident was discharged to the [redacted].

The surveyor reviewed the MDS 3.0 Assessment

F 640

3 discharged assessments were completed and submitted.

Residents with an MDS scheduled to be transmitted prior to [redacted] had the potential to be affected. Upon review, no other residents affected.

Nurse Case Management Department has been educated by the Regional Director of Nurse Case Management of the RAI guidelines as it pertains to transmission of discharge assessments. Center Director of Nurse Case Management to utilize daily action summary report from PCC to ensure timely completion of discharge MDS assessments.

Center Director of Nurse Case Management will audit 5 discharge charts each week x 4 weeks, then 3 discharge assessment x 2 weeks, then 5 charts monthly x 3 months to ensure discharge assessment completed and transmitted timely. Findings will be reported to the center QAPI committee monthly for 4 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

(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 640	Continued From page 4	F 640		

History assessment tool, including all the completed MDS's for the resident. The MDS assessment history revealed that there was no Discharge Assessment MDS completed for the resident's discharge date of [redacted].

3.) On 9/4/19 at 10:50 AM, the surveyor reviewed Resident #70's electronic medical record. The record revealed that the resident was admitted to the facility on [redacted] with diagnosis that included [redacted]. Further review of the record revealed that the resident was discharged [redacted] 9.

The surveyor reviewed the MDS 3.0 Assessment History assessment tool, including all the completed MDS's for the resident. The MDS assessment history revealed that there was no Discharge Assessment MDS completed for the resident's discharge date of [redacted].

According to the latest version of the Center for Medicare/Medicaid Services - Resident Assessment Instrument 3.0 Manual (updated October 2018) page 2-11 "Discharge refers to the date a resident leaves the facility. There are two types of OBRA required discharges: return anticipated and return not anticipated. A Discharge assessment is required with all types of discharges. The manual revealed on Page 2-17 "A Discharge Assessment - return not anticipated MDS must be completed not later than discharge date + 14 days. The assessment must also be transmitted to the QIES ASAP system not later than the MDS completion + 14 days."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	**W-90 RIDGEWOOD AVE PARAMUS, NJ 07652**

(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 640	Continued From page 5 On 9/4/19 at 11:47 AM, the surveyor spoke with the MDS Coordinator who confirmed that there were no discharge assessment MDS's completed for Resident #1, #2 and #70. On 9/4/19 at 1:00 PM, the surveyor informed the Administrator and the Director of Nursing regarding the above concern. They did not provide any further information. NJAC 8:39-11.2	F 640		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a.) store potentially hazardous foods in a manner	F 812	No residents were affected. Residents being served from the center	10/1/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

(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 812	Continued From page 6 to prevent food borne illness and b.) failed to maintain adequate hand washing practices during meal services. This deficient practice was evidenced by the following: On 08/31/19 at 8:53 AM, in the presence of the Food Service Director (FSD) and the Regional FSD, the surveyor observed the following: 1. Inside the Milk refrigerator, the surveyor observed an opened and undated one gallon of regular milk with an expiration date of 9/6/19. The FSD stated, "I opened the milk this morning for the eggs. I should have dated the milk." Inside the reach-in freezer, the surveyor observed the following: 2. Two frozen hamburger patties wrapped in aluminum foil with a use by date of 8/29/19. The Regional FSD discarded the hamburger patties in the presence of the surveyor. 3. One package of Asian style frozen vegetables stored in a plastic bag inside a cardboard box which was opened and undated. The box did not have a receive date. The FSD discarded the frozen vegetables in the presence of the surveyor. The FSD could not speak to why the box of frozen vegetables did not have a receive date and said it should have. 4. There was one package of frozen cookie dough in a plastic bag inside a cardboard box which was opened and undated. There was no receive date on the box. The FSD discarded the cookie dough in the presence of the surveyor and	F 812	kitchen had the potential to be affected. Dietary Department has been educated by the Culinary Director of the timely dating of open items and labeling and dating tool. Culinary Department has been in serviced by the Assistant Director of Nursing on hand hygiene to include hand washing. Hand washing competencies will be completed for dietary personnel. Culinary designee will conduct audit to ensure compliance with label and dating. Culinary Director or designee to complete labeling and dating tool daily for 7 days for 4 weeks, then 3x/week for 8 weeks, then weekly x 4 weeks and then monthly x 2 months. Assistant Director of Nursing to do hand washing competencies daily x 2 weeks, then 3x/week x 4 weeks, then weekly x 2 months. Findings will be reported to the center QAPI committee monthly for 4 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

(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 812	Continued From page 7 said the box should have been dated when the plastic bag containing the cookie dough was opened and there should have been a receive date on the box. 5. There was a box of fully cooked sausage opened and undated. The FSD discarded the sausage in the presence of the surveyor. 6. There was a three-gallon container of chocolate ice cream opened and undated. There was no receive date on the ice cream container. The FSD discarded the chocolate ice cream in the presence of the surveyor and said he did not know why there was no receive date on the container. The surveyor reviewed the facility's undated policy titled, "Food Labeling Guidelines." The policy indicated that "All items are dated with the delivery date including month/day/year on the case or container stored in to ensure FIFO (first in first out). Items are labeled and sealed when opened with the opening date and the name of the item if it is not clearly identifiable. Items are checked routinely for 'use by' dates and used or discarded. The manufactures expiration date, when available, is the 'use by' for unopened items." On 8/30/19 at 12:15 PM, during the lunch observation in the dining room on the [redacted] floor, the surveyor observed the Activity Assistant #1 turned on the faucet, applied soap to her	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

(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 812	Continued From page 8	F 812		

hands and immediately rinsed her hands under running water.

On 9/3/19 at 11:57 AM, during the lunch observation in the [redacted] floor dining room, the surveyor observed the Dietary Aide turned on the faucet, applied soap to her hands and immediately rinsed her hands under running water. The Dietary Aide (DA #1) dried her hands and used the same paper towel to turn off the faucet.

On that same day at 12:00 PM, the surveyor observed Activity Assistant #2 applied soap to her hands and washed them under running water.

On that same day at 12:13 PM, the surveyor observed DA #1 turned on the faucet, applied soap to her hands and immediately rinsed her hands under the running water. DA #1 applied soap to her hands 3 times and immediately rinsed her hands under running water each time.

On that same day at 12:18 PM, the surveyor observed the Dietary Chef remove his gloves and don a new pair gloves without first washing his hands. He then left the steam table area to discard a plate of "cold food." When he reentered the steam table area he removed his gloves, turned on the faucet, applied soap to his hands and immediately rinsed his hands under running water.

On 9/5/19 at 12 PM, during the lunch meal observation, the surveyor observed DA #1 washed her hands. DA #1 used the same paper towel to dry her hands and turn off the faucet.

The surveyor reviewed the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315426	A. BUILDING ______ B. WING ______	09/06/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT RIDGEWOOD AVENUE	W-90 RIDGEWOOD AVE PARAMUS, NJ 07652

(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 812	Continued From page 9	F 812		

Handwashing/Hand Hygiene Policy dated 2001 and revised August 2015 which reflected:

1. Wet hands first with water, apply soap and vigorously rub hands together creating friction to all surfaces for a minimum of 20 seconds (or longer.)
2. Rinse hands thoroughly under running water.
3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel.

Use an alcohol- based hand rub containing at least 62% alcohol; or alternatively soap and water after removing gloves.

On 9/3/19 at 12:32 PM, the survey team brought the above observation and concern to the attention of the Director of Nursing (DON) and the Administrator. The DON stated that the Dietary staff and the Activity staff were not following the facility's policy on Hand Hygiene and would be inserviced immediately.

No further information was provided.

NJAC 8:39-17.2(g)
NJAC 8:39-19.4 (n)