STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60218	A. BUILDING: _____ B. WING _____	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

(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) COMPLETE DATE
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: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes.	S 560	1. ID Prefix Tag S560 2. How the corrective action will be accomplished for those residents found to have been affected by this practice. The leadership team has met on an ongoing basis and continues to identify staffing challenges and areas of improvement and recruitment for certified nursing assistants necessary to maintain the required minimum direct care to staff	1/6/23

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

Electronically Signed | 01/05/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60218	A. BUILDING: _____ B. WING _____	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

(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) COMPLETE DATE
S 560	Continued From page 1 Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties: and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be	S 560	ratios as required. 3. 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. 4. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice will not recur. The facility has implemented a significant above-market rate increase for nurses and certified nursing assistants. Incentives are offered which include tuition reimbursement, sign-on bonus, employee referral program and additional training if not certified. The facility continues to conduct job fairs with on-the-spot interviews, as well as walk-in applicants and has the ability to expedite contingency offers at the time of interview. 5. How the facility will monitor its corrective actions to ensure that the deficient practice will not recur, i.e. what quality assurance program will be put into place The DON or Designee will monitor the certified nursing aide staffing ratios and document a weekly review of the daily staffing X 4 weeks then twice monthly for two months. The Staffing audits will be presented to the Administrator. The DON or Designee will present the result of the audits to the Quality Assurance Performance Improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60218	A. BUILDING: _____ B. WING _____	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

(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) COMPLETE DATE
S 560	Continued From page 2 rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins. d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of the "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the two weeks beginning 11/27/22 and ending 12/10/22 revealed that the facility was not in compliance with the State of New Jersey minimum staffing requirement. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -11/27/22 had 8 CNAs for 91 residents on the day shift, required 11 CNAs. -11/28/22 had 8 CNAs for 91 residents on the day shift, required 11 CNAs. -11/29/22 had 8 CNAs for 91 residents on the day shift, required 11 CNAs. -11/30/22 had 8 CNAs for 91 residents on the day shift, required 11 CNAs. -12/01/22 had 8 CNAs for 91 residents on the day shift, required 11 CNAs. -12/02/22 had 7 CNAs for 91 residents on the day shift, required 11 CNAs. -12/03/22 had 10 CNAs for 91 residents on the	S 560	committee for review on a monthly basis for three months. The Committee will review and revise the plan if needed. 6. Timeframe Weekly X 4 weeks until 1/13/23 and then monthly thereafter	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	60218	A. BUILDING: _____ B. WING _____	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

(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) COMPLETE DATE
S 560	Continued From page 3 day shift, required 11 CNAs. -12/04/22 had 9 CNAs for 91 residents on the day shift, required 11 CNAs. -12/05/22 had 9 CNAs for 90 residents on the day shift, required 11 CNAs. -12/06/22 had 8 CNAs for 90 residents on the day shift, required 11 CNAs. -12/07/22 had 10 CNAs for 90 residents on the day shift, required 11 CNAs. -12/08/22 had 9 CNAs for 89 residents on the day shift, required 11 CNAs. -12/09/22 had 8 CNAs for 89 residents on the day shift, required 11 CNAs. -12/10/22 had 8 CNAs for 87 residents on the day shift, required 11 CNAs. On 12/16/22 at 10:35 AM, the surveyor interviewed a Certified Nursing Assistant (CNA#1) on unit B who stated that she usually cares for 12 residents per shift. She was aware that she should only be caring for 8 residents per shift. She acknowledged that the facility has some shortages in staffing. On 12/19/22 at 2:00 PM, the surveyor team met with the facility administration team that included the Licensed Nursing Home Administrator discussed the concerns with the facility staffing. The administration staff were informed that the facility did not meet the State of New Jersey minimum staffing for the period of 11/27/22 to 12/10/22. No further information was provided to the surveyor team.	S 560		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60218 (Y1)	A. Building B. Wing (Y2)	2/9/2023 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT VALLEY	300 OLD HOOK ROAD WESTWOOD, NJ 07675

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 01/06/2023	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
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

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
12/19/2022

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

 EVENT ID: 1FWZ12

STATE FORM: REVISIT REPORT (11/06)