STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING _____ B. WING _____	08/17/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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		
F 000	INITIAL COMMENTS Standard Survey: 8/17/22 Census: 77 Sample Size: 22 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities. Deficiencies were cited for this survey.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		9/7/22

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

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F 880	Continued From page 1 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 2 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. 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 1.) appropriately put on personal protective equipment (PPE) while in the rooms of residents on transmission-based precautions (TBP). This was observed for1 of 1 housekeepers on the unit, and 2.) failed to appropriately handle potentially contaminated items coming from TBP rooms for 2 of 2 Certified Nursing Assistants (CNA) observed and evidenced by the following: 1. On 8/4/22 at 10:45 AM, the surveyor observed a sign on the door to resident room [redacted] which indicated that the residents were on "Isolation Droplet/ Contact Precautions" and that PPE including a gown, N-95 respirator, eye protection, and gloves should be worn while in the room. At the same time the surveyor observed the housekeeper inside room [redacted] mopping the floor. The surveyor observed that the housekeeper wore a gown, N-95 respirator, and eye protection but did not have gloves on and mopped with bare hands. On 8/4/22 at 10:46 AM, the surveyor interviewed the Housekeeper. The surveyor asked what type of unit this was. The housekeeper stated that it was a COVID-19 unit. The surveyor asked if he	F 880	1. ID Prefix Tag F Tag 880 SS=D 2. How the Corrective Action will be Accomplished for those residents founds to have been affected by the Practice. Housekeeper #1 was removed from the unit and an immediate inservice on Covid-19 policy and procedures and infection control processes was provided including observation for return demonstration competency. C.N.A.#1 and C.N.A. #2 were immediately inserviced on Covid-19 policy and procedures and infection control processes. 3. How the Facility will identify other residents having the potential to be affected by 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	

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F 880	Continued From page 3 was in a COVID-19 room. The housekeeper stated, "this is a COVID room". The surveyor asked what kind of PPE he needed to wear in a COVID-19 room. The housekeeper stated that he wore goggles, a face mask, and a gown. The surveyor asked if the housekeeper needed to wear gloves while in the room. The housekeeper gestured to the housekeeping cart outside of the room which held his cleaning supplies and stated that he had gloves but that he took the gloves off after he changed the mop head. The surveyor asked if the Housekeeper should have put new gloves on after changing his gloves. The housekeeper did not respond. On 8/4/22 at 10:56 AM, the surveyor observed that the housekeeper's cart was still outside of room [redacted] and that two plastic meal trays were positioned on top of the cart. The surveyor observed that each meal tray had several items on it including utensils, plates, and cups. At this time the surveyor observed CNA #1 and CNA #2 each pick up one of the meal trays. The surveyor followed CNA #1 and CNA #2 as they walked through three doors and several hallways carrying the meal trays. CNA #1 and CNA #2 brought the meal trays to the kitchen and left the trays on a metal tray truck which held several meal trays. On 8/4/22 at 10:58 AM, the surveyor interviewed CNA #1 and CNA #2. The surveyor asked why they were carrying meal trays from a COVID-19 room to the kitchen. CNA #1 stated that kitchen staff took the tray truck before the residents in room [redacted] were finished eating. The surveyor asked if this was normally the way that they would bring meal trays that were in a COVID-19 room back to the kitchen. CNA #1 stated that normally they would go on the tray truck but that it was not	F 880	recur. The Facility conducted an in-depth Root Cause Analysis (RCA) on the events related to the infection control concern and found that the Housekeeper had removed gloves after changing the mop head and then did not realized he had forgotten to don a clean pair of gloves. When questioned by the surveyor, the housekeeper became nervous and did not interpret and answer question correctly. C.N.A. #1 and C.N.A. #2 did not confirm what room the meal trays were taken from and did not cover properly while transporting to the kitchen. After interview with the Housekeeper related to each scenario, he was able to identify and demonstrate the correct steps of donning a clean pair of gloves after mop head changes. Housekeeper was shadowed by Regional Director of Environmental Services and was able to demonstrate step by step best practice of the sequence of cleaning rooms. After interview with C.N.A. #1 and C.N.A. #2 both were able to verbalize the process of transporting meal trays to they kitchen. The DON or Designee re-educated the housekeeper and C.N.A. #1 and C.N.A. #2 on Donning and Doffing PPE, Infection control policies and procedures, which include Identification and Management of Ill Residents, Cleaning and Disinfecting and General Cohort Guidelines. The three staff members demonstrated competency. The DON or Designee will use an infection control tool during audit and competency observation.	

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F 880	Continued From page 4 on the nursing unit. The surveyor asked if it was alright to transport meal trays from COVID-19 rooms to the kitchen in this way. CNA #1 stated that the housekeeper used wipes on the trays and sanitized them and that the trays were clean. The surveyor stated that there were several items on the tray and how were they sure all items were sanitized. CNA #1 restated that the trays were clean. On 8/4/22 at 11:30 AM, the surveyor interviewed the Licensed Practical Nurse Unit Manager (LPN/UM). The surveyor described her observation, that CNA #1 and CNA #2 carried meal trays from a COVID-19 room into the kitchen. The LPN/UM stated that this was not an acceptable way to transport meal trays that were in a COVID-19 room. The surveyor asked what the proper way to transport the meal trays from the COVID-19 room was. The LPN/UM stated that the meal trays should be in the closed meal tray truck. On 8/4/22 at 11:57 AM, the surveyor interviewed the Regional Environmental Services Director (RESD). The surveyor described how she observed the housekeeper in a COVID-19 room mopping without gloves. The RESD stated that the housekeeper should have been wearing gloves in the COVID-19 room. The surveyor also stated that the housekeeper had meal trays from a COVID-19 room on top of his housekeeping cart. The RESD stated that the housekeeper should not take meal trays out of resident rooms and should not have touched the meal trays. On 8/4/22 at 12:02 PM, the surveyor interviewed the housekeeper. The surveyor asked if the housekeeper took the trays out of room [redacted] and	F 880	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 utilize infection control audit tool to audit upto 5 staff weekly for 4 weeks, then 10 staff per twice monthly for two months. The DON or Designee will continue infection control audits thereafter upto 10 per month. Results of the Infection control audits will be reported at the Quality Assurance Performance Improvement committee meetings on a monthly basis for three months for review and to determine the need for further education or revisions to the plan. 6. Directed in-service training completion. a. Module 1 - Infection Prevention & Control program - training provided to topline staff and infection preventionist. https://www.train.org/main/course/1081350/ (topline staff and infection preventionist) b. CDC Covid-19 Prevention Messages for front line long term care staff: Keep Covid-19 Out! - training provided to front line staff. https://youtu.be/t7Oh80Rr5Ig c. CDC Covid-19 prevention messages for front line long-term care staff: Sparkling surfaces. https://youtu.be/t7OH8ORr5Ig. training provided to front line staff. d. CDC Covid-19 prevention messages	

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F 880	Continued From page 5 put them on the housekeeping cart. The housekeeper acknowledged that he did. The surveyor asked if he sanitized the meal trays when he took them out of the COVID-19 room. The housekeeping aide stated, "how would I clean the tray, there's food on it?". The surveyor reviewed the facility's policy titled, Coronavirus Disease (COVID-19)- Identification and Management of Ill Residents with a revised date of 8/22 indicated that "residents who test positive for COVID-19 are cared for by staff using a NIOSH approved N95 or equivalent or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves, and a gown." The surveyor reviewed the facility's policy titled, Coronavirus Disease (COVID-19)- Cleaning and Disinfecting reviewed 12/21, indicated to "clean and disinfect areas, material and equipment that have likely been contaminated by a person with COVID-19 in the last 24 hours using a disinfectant found on the EPA's List N (disinfectants effective against COVID-19)." 2. On 8/5/22 at 11:00 AM, the surveyor observed a housekeeper don (put on) PPE appropriately, outside the room of a resident who was on contact and droplet precautions due to a Covid-19 infection [redacted] room) as evidenced by a red sign posted on the door that read: "Isolation Droplet/Contact Precautions". When the housekeeper came out of the room the surveyor asked the housekeeper how he doffed (removed) PPE and what order he cleaned the resident rooms. He described appropriately how he doffed PPE but when describing the order in which he cleaned the rooms he said he cleaned	F 880	for front line long term care staff: Use PPE Correctly for Covid-19. https://youtu.be/YYTATw9yav4. training provided to front line staff e. Nursing Home Infection Preventionist Training Course - Module 5 Outbreaks. https://www.traing.org/cdctrain/course/108183. training provided to topline staff and infection preventionist. f. Nursing Home Infection Preventionist Training Course - Module 11B - Environmental Cleaning and Disinfection. https://www.train.org/main/course/108181 5. training provided to all staff including top line staff and infection preventionist. g. Nursing Home Infection Preventionist training course Module 6A Principles of Standards Precautions https://www.train.org/main/course/108180 4. training provided to all staff including top line staff and infection preventionist h. Nursing Home Infection Preventionist training course Module 6B Principles of Transmission Based Precautions https://www.train.org/main/course/108180 5. training provided to all staff including topline staff and infection preventionist. 7. Timeframe Audits Weekly X 4 weeks until 10/8/22 and then monthly thereafter. DPOC inservice and education will be completed as required by 9/20/22.	

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F 880	Continued From page 6 the red rooms first. On 8/5/22 at 11:20 AM the surveyor observed the housekeeper in the hallway outside of the shower room next to the Covid-19 positive room he had just cleaned. He said he already cleaned the [redacted] room and the shower room next to it. He said he cleaned the [redacted] rooms first and then the [redacted] rooms (residents who were on contact and droplet precautions due to exposure to Covid-19, or new admissions), and then the [redacted] rooms (residents who had no known exposure to Covid-19). The surveyor asked the Infection Preventionist (IP) what order the housekeeper should have cleaned the resident rooms, the IP said [redacted] rooms first, then [redacted] rooms, then [redacted] rooms last, using a well to ill flow in accordance with guidance from Centers for Disease Control and Prevention. The surveyor confirmed with the IP that the rooms in question were rooms of residents who were on isolation due to a confirmed positive test result for Covid-19 infection. She further confirmed that there were two rooms that were coded as [redacted] for having residents in them who had Covid-19, and she pointed out those rooms. On 8/5/22 at 11:25 AM the surveyor asked the RESD what order the housekeeper should have been cleaning the rooms with respect to different cohorts, [redacted], [redacted], and [redacted] He said the housekeepers should clean the [redacted] rooms first, then the [redacted] rooms, then the [redacted] rooms last. The surveyor joined the RESD when he went to speak with the housekeeper. When the surveyor and RESD approached the housekeeper he was donning PPE outside of a [redacted] room.	F 880		

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F 880	Continued From page 7	F 880		

The RESD explained to him what order to clean the rooms. The housekeeper did confirm that he had finished cleaning a [redacted] room and was going to clean the second [redacted] room then he would clean the [redacted] and the [redacted] rooms. The RESD said he was going to get an interpreter and explain to the housekeeper in his own language. As the surveyor and the ESRD were walking away the housekeeper, who was wearing full PPE (N95 mask, goggles, gown, gloves), started to enter the [redacted] room. The ESRD stopped the housekeeper from entering the [redacted] room and said to wait there and he would be right back. The housekeeper waited outside the [redacted] room. The ESRD came back within a few minutes and asked the housekeeper to go with him for training with an interpreter and they left the unit.

On 8/5/22 at 1:20 PM, the surveyors discussed the above concerns to the Administrator and Director of Nursing. No additional information was provided.

The surveyor reviewed the policy and procedure titled "General Cohort Guidelines." The guidelines described the different cohorts as follows: "Red (Confirmed Covid Positive), Yellow (Potentially Incubating, not up to date with vaccinations and exposed or newly admitted), Green (Naive, negative, recovered, vaccinated, asymptomatic, no known exposure, admits/readmits post quarantine, Covid recovered/released from transmission based precautions)."

08/17/22 10:26 AM, the surveyor asked the DON for the policy and procedure the housekeeper or nursing would follow to address the well to ill flow when entering rooms for care or cleaning. She

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F 880	Continued From page 8 said they didn't have a policy but that was their practice. NJAC 8:39-19.4 (a)	F 880		

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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: Based on the interview, and record review, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the State of New Jersey. The facility was deficient in CNA staffing for 12 of 14 day shifts reviewed and this deficient practice had the potential to affect all residents. Findings included: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance	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 ratios as required.	9/8/22

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S 560	Continued From page 1 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, 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....." The facility provided the completed Nurse Staffing Reports for the period of 7/17/22 through 7/30/22. CNA to resident staffing ratios did not meet the minimum requirement of 1 CNA to 8 residents for 12 of 14 day shifts as documented below: -07/17/22 had 7 CNAs for 76 residents on the day shift, required 9 CNAs. -07/18/22 had 7 CNAs for 76 residents on the day shift, required 9 CNAs. -07/21/22 had 8 CNAs for 77 residents on the day shift, required 10 CNAs. -07/22/22 had 8 CNAs for 77 residents on the day shift, required 10 CNAs. -07/23/22 had 7 CNAs for 77 residents on the day shift, required 10 CNAs. -07/24/22 had 8 CNAs for 83 residents on the day shift, required 10 CNAs. -07/25/22 had 8 CNAs for 79 residents on the day shift, required 10 CNAs. -07/26/22 had 8 CNAs for 77 residents on the day shift, required 10 CNAs. -07/27/22 had 7 CNAs for 77 residents on the day shift, required 10 CNAs. -07/28/22 had 8 CNAs for 76 residents on the day shift, required 9 CNAs. -07/29/22 had 8 CNAs for 74 residents on the day shift, required 9 CNAs.	S 560	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 committee for review on a monthly basis for three months. The Committee will	

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	60218	A. BUILDING: _____ B. WING _____	08/17/2022

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D 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 -07/30/22 had 6 CNAs for 74 residents on the day shift, required 9 CNAs. On 8/17/22 at 12:30 the surveyor discussed the below minimum staffing ratios with the Administration and the Director of Nursing.	S 560	review and revise the plan if needed. 6. Timeframe Weekly X 4 weeks until 10/8/22 and then monthly thereafter	

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
315369 (Y1)	A. Building B. Wing (Y2)	10/21/2022 (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 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 F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 09/07/2022	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	
8/17/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
60218 Y1	A. Building B. Wing Y2	10/21/2022 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 09/08/2022	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
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 8/17/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?		☐ YES ☐ NO	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING **01** B. WING _____	**08/17/2022**

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 DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 8/16/22 and 8/17/2022 and Care One at Valley 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 Occupancies. Care One at Valley is a single story, Type V Protected building that was built in January 1960. The facility is divided into 4 smoke zones.	K 000		
K 111 SS=F	Building Rehabilitation CFR(s): NFPA 101 Building Rehabilitation Repair, Renovation, Modification, or Reconstruction Any building undergoing repair, renovation, modification, or reconstruction complies with both of the following: * Requirements of Chapter 18 and 19 * Requirements of the applicable Sections 43.3, 43.4, 43.5, and 43.6 18.1.1.4.3, 19.1.1.4.3, 43.1.2.1 Change of Use or Change of Occupancy Any building undergoing change of use or change of occupancy classification complies with the requirements of Section 43.7, unless permitted by 18.1.1.4.2 or 19.1.1.4.2 18.1.1.4.2 (4.6.7 and 4.6.11), 19.1.1.4.2 (4.6.7 and 4.6.11), 43.1.2.2 (43.7) Additions Any building undergoing an addition shall comply with the requirements of Section 43.8. If the	K 111		9/9/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/07/2022

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.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 111	Continued From page 1 building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a 2-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors with at least a 1-1/2-hour fire resistance rating. Additions comply with the requirements of Section 43.8. 18.1.1.4.1 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3(43.8) This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation on 8/16/2022, in the presence of facility management, the facility failed to provide a two (2) hour fire separation between new construction and an existing nonconforming building in accordance with the requirements of NFPA 101, 2012 Edition, Section 18.1.1.4.4 (4.6.7 and 4.6.11), 18.1.1.4.1.1 (8.3), 18.1.1.4.1.2, 18.1.1.4.1.3, 19.1.1.4.1 (4.6.7 and 4.6.11), 19.1.1.4.1.1 (8.3), 19.1.1.4.1.2, 19.1.1.4.1.3, 43.1.2.3 (43.8). The deficient practice was evidenced for 1 of 1 renovation projects observed by the following: During the survey entrance at 9:50 AM a request was made to the Regional Environmental Services Director (RESD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. The surveyor also asked the RESD if the facility had done any construction or renovation work since the last Re-Certification survey of 2/26/2020. The RESD said, yes and told the surveyor that the facility had an addition built and there was an initial	K 111	1. ID Prefix Tag K 111 SS=F 2. How the corrective action will be accomplished for those residents found to have been affected by this practice. The facility will provide a two hour fire separation between new construction and an existing nonconforming building as required. The facility will install a self-closure with positive latching to the corridor door that leads into the existing building corridor. Due to the continued disruptions in the national supply chain, materials may be delayed and a Time Limited Waiver is requested. The estimated completion date of the project is 6/1/2023. 3. How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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	315369	A. BUILDING **01** B. WING _____	**08/17/2022**

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K 111	Continued From page 2 inspection conducted on 01/19/2021. At approximately 10:00 AM, the RESD provided a copy of the facility lay-out which identified the various rooms in the building. The surveyor asked the RESD to identify the new construction addition to the building on the lay-out. The RESD identified the separation with an orange highlighted line on the lay-out. A review of the lay-out identified that there are 10 Resident sleeping room's and one Nurses Station. Starting at 10:19 AM during a tour of the building in the presence of the RESD was conducted. At approximately 11:18 AM, an inspection outside of existing building where the New Assisted Living building that was under construction was performed. The surveyor observed that the two hour fire resistant wall had the following penetrations through the wall, 1) One nine inch by 16 inch through the masonry wall into the attic area. 2) The facility had removed the double 90 minute fire rated doors and installed two pieces of plywood to cover the eight (8) feet high by six feet six inch opening through the wall into the existing building. Later at approximately 11:00 AM during the building tour with the RESD an inspection of the new construction addition to the building was conducted. During a closure test of the double fire rated corridor doors located in the two hour fire separation wall was performed. When the doors were release from their magnetic door hold open devices, the doors did not positive latch into their	K 111	All resident 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 will have installed a two hour fire separation between new construction and existing nonconforming building. The Facility will install a self closer with positive latching on the corridor door on the renovated nurses station. 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 Director of Environmental Services will use Environmental audit tool to audit that facility has two hour fire separation doors with positive latching as required as well as doors with self closers X 4 weeks for the first month and then monthly thereafter. Results of the Environmental audit tool will be reported to the Quality Assurance Performance Improvement committee on a monthly basis for the first two months. 6. Timeframe: Audit weekly X 4 weeks until 10/8/22 and then monthly thereafter X 2 months	

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K 111	Continued From page 3 frame as required to maintain the fire rated construction. The surveyor observed a gap approximately two inches between the meeting edges near the bottom of the doors. The surveyor observed in the renovated Nurses Station a corridor door that leads into the existing building corridor. During a closure test of the corridor door the door did not self-close into its frame. The surveyor observed the door had no means to self-close and no 90 minute fire rating label attached to the door. The facility failed to maintain a two hour fire separation between an new construction addition and an existing building. The findings was verified by RESD at the time of the observation's. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM.	K 111		
K 271 SS=F	Fire Safety Hazard. NJAC 8:39-31.2(e) Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by:	K 271		9/26/22

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K 271	Continued From page 4 Based on observation and review of facility provided documentation on 8/16/2022, it was determined that the facility failed to provide 4 of 7 exit discharges with a stable, hard packed all-weather travel surface and maintain a level walking surface, free of all obstructions and impediments to reach a public way (street or parking lot) in the case of fire or other emergency in accordance with National Fire Protection Association (NFPA) 101, 2012 Edition, Section 19.2, 19.2.1, 19.2.7, 7.7, 7.7.1, 7.7.3.2, 7.1.6, 7.1.6.2, 7.1.6.3, 7.1.10, 7.1.10.1. and the New Jersey Uniform Construction Code 5:23. This deficient practice was evidence by the following: Reference: New Jersey Uniform Construction Code 5:23: International Building Code, 1. Section 1002 Definitions, Means of egress: "A continuous and unobstructed path of vertical and horizontal egress travel from any occupied portion of a building or structure to a public way. A means of egress consists of three separate and distinct parts, the exit access, the exit and exit discharge." 2. Section 1011, Exit signs: "1011.1 Where required. Exits and exit access doors shall be marked by an approved exit sign readily visible from any direction of egress travel. Access to exits shall be marked by readily visible exit signs in cases where the exit or the path of egress travel is not immediately visible to the occupants. Exit sign placement shall be such that no point in an exit access corridor is more than 100 feet or listed viewing distance for the sign, whichever is less, from the nearest visible exit sign."	K 271	1. ID Prefix Tag K271 SS=F 2. How the corrective action will be accomplished for those residents found to have been affected by the practice. The facility will install a hard packed all-weather travel surface and maintain a walking surface to reach a public way in the new addition area. A time-limited waiver is requested. Estimated completion date of project is 12/16/22. 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 Director of Environmental Services will install a hard packed all weather travel surface and maintain a level walking surface for #4 of the 7 exit discharge areas. 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 Director of Environmental Services will complete an Environmental audit tool for designated exit discharge door X4 weeks for the first month and then	

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K 271	Continued From page 5 During the survey entrance at 9:50 AM a request was made to the Regional Environmental Services Director (RESD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified there are seven exit discharge doors located in the facility. Starting at 10:19 AM in the presence of the RESD during a tour of the building was conducted. At approximately 11:05 AM, an inspection of the new addition area was performed. The surveyor observed outside a designated exit discharge door (an illuminated exit sign above the door) that the exit discharge path (approximately 300 feet long) lead to the facility garbage dumpster area. The discharge path by the dumpster area was blocked with construction material, metal framing studs and plywood. There was no clear and unobstructed path to reach a public way. A review of the facility provided lay-out identified that there are four designated exit discharge doors (illuminated exit signs above the doors) that would lead you to that discharge path to reach a public way. The RESD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM. Fire Safety Hazard. NJAC 8:39-31.1(e) NFPA 101:2012 - 7.7 NFPA 101:2012- 19.2 Means of Egress	K 271	monthly thereafter. Results of the Environmental audit tool will be review by the Quality Assurance Performance Improvement committee on a monthly basis for the first two months. Revisions will be made if necessary. 6. Timeframe Audit weekly X4 weeks until 10/8/22 and then monthly thereafter X 2 months	

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K 271	Continued From page 6 Requirements	K 271		
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation on 8/16/2022, the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affects 1 of 5 exit discharge areas observed and was evidenced by the following: During the survey entrance at 9:50 AM a request was made to the Regional Environmental Services Director (RESD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. The surveyor also asked the RESD if the facility had done any construction or renovation work since the last Re-Certification survey of 2/26/2020. The RESD said, yes and told the surveyor that the facility had an addition built and there was an initial inspection conducted on 1/19/2021. At approximately 10:00 AM, the RESD provided a copy of the facility lay-out which identified the various rooms in the building. The surveyor asked the RESD to identify the new construction addition to the building on the lay-out. The RESD	K 281	1. ID Prefix Tag K281 SS=E 2. How the corrective action will be accommplished for those residents found to have been affected by the practice. The facility will provide an illumination of means of egress of emergency lighting along the discharge path of the new building. 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 will install egress of emergency lighting along the discharge path of the new building.	9/26/22

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CAREONE AT VALLEY	**300 OLD HOOK ROAD** **WESTWOOD, NJ 07675**

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K 281	Continued From page 7 identified the separation with an orange highlighted line on the lay-out. A review of the lay-out identified that there are ten Resident sleeping room's and one Nurses Station. Starting at 10:19 AM during a tour of the building in the presence of the RESD was conducted. At approximately 11:10 AM, an inspection outside of New addition exit discharge door was performed. The surveyor observed no evidence of emergency lighting along the approximately 90 feet discharge path of the new building. The findings was verified by RESD at the time of the observation's. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	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 Director of Environmental Services will use Environmental Audit tool to audit that facility has required egress of emergency lighting X 4 weeks for the first month and then monthly thereafter. Results of the Environmental audit tool will be reported to the Quality Assurance performance improvement committee on a monthly basis for the first two months. 6. Time frame Audit weekly for first 4 weeks until 10/8/22 and then monthly thereafter for two months.	
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by:	K 293		9/26/22

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K 293	Continued From page 8 Based on observation and review of facility provided documentation on 8/16/2022 in the presence of facility management, it was determined that the facility failed to ensure that illuminated exit signs were in four locations to clearly identify the exit access path to reach an exit discharge door. This deficient practice was evidenced by the following: Reference: NFPA. Life Safety Code 2012 7.10.1.5.1 Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. NFPA Life Safety Code 2012 7.10.5.2.1 Continuous Illumination. Every sign required to be illuminated by 7.10.6.3, 7.10.7, and 7.10.8.1 shall be continuously illuminated as required under the provisions of section 7.8, unless otherwise provided in 7.10.5.2.2 During the survey entrance at 9:50 AM a request was made to the Regional Environmental Services Director (RESD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. A review of the facility provided lay-out identified there is one enclosed center court yard located between Station three and the Service corridor. Later starting at 10:19 AM during a tour of the building with the RESD, the surveyor observed that facility failed to provide four illuminated exit signs in the following locations, 1) At approximately 10:40 AM, one illuminated	K 293	1. ID Prefix Tag K293 SS=E 2. How the corrective action will be accomplished for those residents found to have been affected by the practice. Illuminated exit signs will be installed in the four locations identified to clearly identify the exit path to reach an exit door. Locations include space above the corridor double smoke doors next to resident room #18, corridor of new addition near day room, and one above each access door in the outside enclosed center courtyard. 3. How will the facility identify other residents having the potential to be affected by same deficient practice. All residents have the potential to be affected. 4. What measures will be put into place of what systemic changes will be made to ensure that the deficient practice will not recur. The facility will install exit lights in areas specified to identify exit paths to reach an exit door. 5. How will the facility monitor its corrective actions to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place. The Director of Environmental Services will use Environmental audit tool to audit that facility has exit lights in specified areas as required X 4 weeks for the first	

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K 293	Continued From page 9 exit sign above the corridor double smoke doors next to Resident room #18. When the fire alarm is activated the magnetic hold open devices release the corridor doors and you could not see the illuminated exit sign located beyond the double smoke doors by the dining room. A review of an emergency evacuation diagram posted in the area, identify this is a primary and secondary exit access route to reach an exit. 2) At approximately 11:11 AM, one illuminated exit sign in the corridor of the new addition near the Day Room. 3) At approximately 12:39 PM, two illuminated exit signs (one above each exit access door) in the outside enclosed center courtyard. The RESD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM. Fire Safety Hazard. NJAC 8:39 -31.1 (c) NFPA Life Safety Code 101	K 293	month and then monthly thereafter. Results of the Environmental audit tool will be reported to the Quality Assurance Performance Improvement committee on a monthly basis for the first two months. 6. Timeframe Audit weekly X 4weeks until 10/8/22 and then monthly thereafter X 2 months.	
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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	K 321		9/1/22

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K 321	Continued From page 10 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 review of facility documentation, it was determined that the facility failed to ensure that fire-rated doors to hazardous areas were self-closing and were separated by smoke resisting partitions 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 practiced was identified in 1 of 1 Medical Records room and 1 of 3 boiler rooms as evidenced by the following: During the survey entrance on 8/16/22 at 9:50 AM a request was made to the Regional	K 321	1. ID Prefix tag K321 SS=E 2. How the corrective action will be accomplished for those residents found to have been affected by the practice. The holes in the fire rated door to the nurses station #2 door were repaired. A self closer was installed to the medical records fire rated door. 3. How the facility will identify other residents having the potential to be	

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K 321	Continued From page 11 Environmental Services Director (RESD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. Later starting at 10:19 AM during a tour of the building with the RESD, the surveyor observed the following Hazardous locations that failed to provide smoke resistant partitions, 1) At 11:57 AM, an inspection inside Station two Nurses Station boiler room identified the fire rated door had one 7/8 of an inch and one 1/2 inch hole through the door. The boiler room had a natural gas boiler in the room. A review of an evacuation diagram posted in the area identified that Station two Nurses Station boiler room was in the primary exit access path to reach an exit. 2) At 12:20 PM, The surveyor observed that the 3/4-hour fire rated corridor door leading into the Medical Records room was in the open position and had no means to self-close the door into its frame. During a closure test of the corridor door it did not close into its frame. The surveyor observed approximately 30 cardboard banker size boxes filled with combustible records. At the time the surveyor in the presence of the RESD , measured and recorded the size of the room, which was nine feet nine inches deep by eight feet wide. The total room measurement was 78 square feet which was larger than 50 square feet. The door failed to self-close into its frame as required by code. A review of an evacuation diagram posted in the area identified that the Medical Records room was in the primary exit access path to reach an exit.	K 321	affected by 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 Director of Environmental Services will ensure that hazardous areas are protected by required fire barrier and door are self-closing. 5. How the facility will monitor its corrective action to ensure that the deficient practice will not recur i.e. what quality assurance program will be put into place. The Director of Environmental Services will use Environmental audit tool to monitor that doors to nurse station #2 have no holes and that self closer is installed to medical records door X4 weeks for the first month and then monthly thereafter. Results of the Environmental Audit tool will be reported to the Quality Assurance Performance Improvement committee on a monthly basis for the first two months. 6. Timeframe Audits done weekly X4 weeks until 10/8/22 and then monthly thereafter X 2 months.	

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K 321	Continued From page 12 This condition would allow fire, smoke and poisonous gases to pass from the Medical Records room into the exit access corridor in the event of a fire. The RESD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM. NJAC 8:39-31.2 (e) Life Safety Code 101	K 321		
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by:	K 341		9/23/22

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K 341	Continued From page 13 Based on observation and interview on 8/16/22 and 8/17/2022 in the presence of facility management it was determined that the facility failed to install supervised smoke detection in accordance with NFPA 101, 2012 Edition, Section 19.3.4.1, 9.6, 9.6.1.8, NFPA 70, 2011 Edition and NFPA 72, 2010 Edition. This deficient practice includes the following, During the survey entrance at 9:50 AM a request was made to the Regional Environmental Services Director (RESD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. The surveyor also asked the RESD if the facility had any construction since the last Re-Certification survey of 1/19/2021. The RESD told the surveyor that the facility is in the process of building a New Assisted Living facility that will be connected to the Long Term Care building. On 8/17/2022 (day two of survey) during the building tour at approximately 10:10 AM, an inspection of Station three section of the facility was performed. The surveyor observed the following, 1) Near the receptionist area the surveyor observed that the Fire Alarm Announciator panel had been relocated. The Red alarm wires were not enclosed in metal conduit to protect the wires. 2) An inspection inside the Magnolia room was conducted. The surveyor observed that the Main Fire Alarm Control panel had been relocated with the Red alarm wires were not enclosed inside metal conduit. 3) The surveyor observed no evidence a smoke detector inside the Magnolia room.	K 341	1. ID Prefix Tag K341 SS=F 2. How the corrective action will be accomplished for those residents found to have been affected by the practice. The facility will have exposed wiring enclosed in the proper conduit as required in the Magnolia Lounge area. 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 Director of Environmental Services will ensure that electrical work is performed as required by code. 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 Director of Environmental Services will use Environmental audit tool to audit that there are no exposed electrical wiring in the Magnolia Lounge X 4 weeks for the first month and then monthly thereafter. Results of the Environmental tool will be reported at the Quality Assurance Performance Improvement committee	

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K 341	Continued From page 14 The RESD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM. NJAC 8:39-31.2(a)	K 341	meeting on a monthly basis for the first two months. 6. Timeframe Audit weekly X4 weeks until 10/8/22 and then monthly thereafter X 2 months.	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and review of facility provided documentation on 8/16/2022, it was determined the facility failed to 1) Provide proper fire sprinkler coverage to all areas of the facility, 2) Did not properly install sprinklers as required by CMS regulation § 483.90(a) physical	K 351	1. ID Prefix Tag K351 SS=E 2. How the corrective action will be accomplished for those residents found to	9/26/22

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K 351	Continued From page 15 environment to all areas in accordance with the requirements of, 1) NFPA 101 2012 Edition, Section 19.3.5.1, 9.7, 9.7.1.1 and National Fire Protection Association (NFPA) 13 Installation of Sprinkler Systems 2012 Edition. 2) As required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy. The evidence includes the following, Reference #2: Uniform Construction Code, Special detailed requirements based on use and occupancy section 407 group I-2, [F] 407.5 Automatic sprinkler system. Smoke compartments containing patient sleeping units shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903.3.1.1. The smoke compartment shall be equipped with approved quick-response or residential sprinklers in accordance with section 903.3.2. During the survey entrance at 9:50 AM a request was made to the Regional Environmental Services Director (RESD) to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. Starting at approximately 10:19 AM, in the presence of facility's RESD a tour of the building was conducted. Along the tour the surveyor observed that the facility failed to provide proper fire sprinkler protection in the following location: 1) At 10:41 AM, outside the exit discharge door of the Evergreen Dining room, the surveyor	K 351	have been affected by the practice. The facility will provide proper fire sprinkler coverage to all areas of the facility including outside the exit door of Evergreen Dining room and station #1 shower room. 3. How the facility will identify other residents having the potential to be affected by 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 will install a sprinkler head under the canopy outside the exit discharge door of the Evergreen Dining room and will resupport the sprinkler head that is inside station #1 shower room. 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 Director of Environmental Services will use Environmental audit tool to audit that facility has proper fire protection coverage to areas identified X4 weeks for the first month and then monthly thereafter. Results of the Environmental audit tool will be reported to Quality Assurance committee on a monthly basis for the first two months.	

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K 351	Continued From page 16 observed no evidence of fire sprinkler protection under the four foot deep by thirteen foot six inch wide canopy. A review of the facility provided lay-out identified that there are ten (10) Resident sleeping rooms in the smoke compartment. 2) At 11:46 AM, inside Station one shower room the surveyor observed one recessed fire sprinkler not set level with the ceiling. This left a 1/4 inch gap in the ceiling tile. This would allow fire (heat) to by pass and not activate the sprinkler head. The RESD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM. Fire Safety Hazard. NJAC 8:39-31.1(c), 31.2(e) NFPA 13.	K 351	6. Timeframe Audits done weekly X4 weeks until 10/8/22 then monthly thereafter X 2 months.	
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and review of facility documentation on 8/16/22 and 8/17/2022 in the presence of facility management, it was determined that the facility failed to Install	K 355	1. ID Prefix Tag K355 SS=D	9/1/22

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K 355	Continued From page 17 portable fire extinguishers with-in the required height for 2 of 16 fire extinguishers, in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.3.5.12, 9.7.4.1 and National Fire Protection Association (NFPA) 10, 2010 Edition, Sections 6.1, 6.1.3.8.1 and 6.1.3.8.3. The evidence includes the following: Reference #1 NFPA 10 - 6.1.3.8 Installation Height. - 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 lb shall be installed so that the top of type fire extinguisher is not more than 5 feet above the floor. - 6.1.3.8.3 In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 inches. On 8/16/2022 starting at 10:19 AM, during a tour of the facility in the presence of the Regional Environmental Services Director (RESD) and continued on 8/17/2022 the surveyor observed sixteen portable fire extinguishers in various locations with the following, 1) At approximately 12:35 PM, the surveyor observed one BC type fire extinguisher inside the Kitchen dry storage room that appeared to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the to the top of the extinguisher five feet nine inches. 2) At approximately 12:41 PM, the surveyor observed one ABC type fire extinguisher in the corridor outside the main Kitchen that appeared	K 355	2. How the corrective action will be accomplished for those residents found to have been affected by the practice. The facility will install fire extinguishers at the proper height in the kitchen dry storage area and the corridor outside the kitchen area. 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 Director of Environmental Services adjusted fire extinguishers to the proper height and clearance in the kitchen dry storage area and corridor outside the main kitchen areas. 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 Director of Environmental Services will use Environmental audit tool to audit that fire extinguishers are installed and mounted at the proper height in specified areas X4 weeks for the first month and then monthly thereafter. Results of the environmental audit tool will be reported to the Quality Assurance Performance Improvement committee on a monthly	

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CAREONE AT VALLEY	**300 OLD HOOK ROAD** **WESTWOOD, NJ 07675**

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K 355	Continued From page 18 to be mounted too high. The surveyor measured and recorded the fire extinguisher was mounted at a height from the floor to the center of the pressure indicating needle five feet four inches. The RESD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM.	K 355	basis for the first two months. 6. Time frame Audit done weekly X4 weeks until 10/8/22 and then monthly thereafter X 2 months.	
K 363 SS=E	NFPA 10 NJAC 8:39 -31.1 (c). 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	K 363		9/26/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING **01** B. WING _____	**08/17/2022**

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

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K 363	Continued From page 19 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 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, interview and review of facility provided documentation on 8/16/2022, in the presence of facility management it was determined that the facility failed to ensure that 10 of 51 Resident room 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 resident room doors restrict the passage of smoke to properly defend occupants in place. This deficient practice was as evidenced by the following: During the survey entrance at 9:50 AM a request was made to the Regional Environmental Services Director (RESD) how many Resident sleeping room are in the facility and to provide a copy of the facility lay-out which identifies the various rooms and smoke compartments. The	K 363	1. ID Prefix Tag K363 SS=E 2. How the corrective action will be accomplished for those residents found to have been affected by the practice. The facility will ensure that 10 of Station A resident room corridor doors are able to resist the passage of smoke with no gaps. 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.	

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	315369	A. BUILDING **01** B. WING _____	**08/17/2022**

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

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K 363	Continued From page 20 RESD told the surveyor that there are 51 Resident sleeping rooms in the building. During the building tour with the RESD at approximately 10:45 AM, an inspection in the new addition wing to the facility was performed. The surveyor observed ten resident rooms had corridor doors that utilize an inactive leaf (to obtain the required 41-1/2 inch clear width opening). When the corridor doors were in the closed position. The surveyor observed and measured a 1/8 of an inch gap between the meeting edges. A review of the facility provided lay-out identified that there are ten resident sleeping rooms in the smoke compartment. This condition would allow fire, smoke and poisonous gases to pass from the residents room into the exit access corridor in the event of a fire. The RESD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM. Fire Safety Hazard 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	The facility will install the proper materials to ensure that resident room corridor rooms have no evidence of gaps and resist the passage of smoke as required. 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 Director of Environmental Services will use Environmental audit tool to monitor that station A corridor doors are able to resist passage of smoke with no gaps X4 weeks for first month and then monthly thereafter. Results of the Environmental audit tool will be reported to the Quality Assurance Performance Improvement committee on a monthly basis for the first two months. 6. Timeframe Audit done weekly X4 weeks until 10/8/22 and then monthly thereafter X 2 months.	
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	K 918		8/18/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315369	A. BUILDING **01** B. WING _____	**08/17/2022**

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

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K 918	Continued From page 21 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. 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 observation and interview on 8/16/2022 in the presence of the facility management, it was determined that the facility failed to ensure a remote manual stop station for 1 of 1 emergency generator was installed in accordance with the requirements of NFPA 110,	K 918	1. ID Prefix Tag K918 SS=F 2. How the corrective action will be accomplished for those residents found to	

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	315369	A. BUILDING **01** B. WING _____	**08/17/2022**

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K 918	Continued From page 22 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. The deficient practice could affect all residents and was evidenced by the following: During the survey entrance 8/16/2022 at 9:50 AM, a request was made to the facility's Regional Environmental Services Director (RESD) if the facility had an emergency generator. The RESD said, yes we have one. Later during the building tour with the facility RESD at approximately 12:32 PM an inspection inside the kitchen dry storage room where the natural gas emergency generator is located was performed. At this time the surveyor asked the RESD, where is the emergency shut off for the generator. The RESD told the surveyor its on the generator. The surveyor observed that the emergency shut off was located on the generator's control panel. The RESD confirmed the findings at the time of observations. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 8/17/2022 at approximately 1:28 PM. NJAC 8:39-31.2(e), 31.2(g) NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1.	K 918	have been affected by the practice. The facility will ensure a remote manual stop station for the emergency generator. 3. How the facility will identify other residents having the potential to be affected by 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 will install a remote annual stop station for the emergency generator on the exterior of the building. 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 Director of Environmental Services will use Environmental audit tool to monitor that there is a remote annual stop station for the emergency generator as required X4 weeks for the first month and then monthly thereafter. Results of the Environmental audit tool will be reported to the quality assurance performance improvement committee on a monthly basis for the first two months. 6. Timeframe Audit done weekly X4 weeks until 10/8/22 and then monthly thereafter X 2 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315369 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	12/6/2022 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 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 K0111	09/09/2022	LSC K0271	09/26/2022	LSC K0281	09/26/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0293	09/26/2022	LSC K0321	09/01/2022	LSC K0341	09/23/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	09/26/2022	LSC K0355	09/01/2022	LSC K0363	09/26/2022
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0918	08/18/2022	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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/17/2022	☐ YES ☐ NO