STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315306	A. BUILDING _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Complaint Survey was conducted on behalf of the New Jersey Department of Health. Complaint #: NJ00162219, NJ00165179, NJ00165673, NJ00169205, NJ00152877, NJ00154769, NJ00156006, NJ00158089, NJ00160103, NJ00160808, NJ00161165, and NJ00165678. Survey Dates: 01/24/24 through 01/26/24 Survey Census: 167 Sample Size: 21 THE FACILITY IS NOT SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG-TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		2/2/24

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

Electronically Signed | 02/16/2024

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 609	Continued From page 1 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Complaint #: NJ00162219 Based on record review staff interviews, and facility policy review, the facility failed to ensure an injury of unknown origin was reported to appropriate entities in a timely manner for one of eleven residents (Resident (R) 1) reviewed for abuse of 21 sample residents. R1 experienced an Ex.Order 26.4(b)(1) and the incident was not reported to the local Ombudsman, the family, or the State Agency. Findings include: Review of R1's "Admission Record," dated Ex.Order 26.4(b)(1) and found in the electronic medical record (EMR) under the "Admissions" tab, indicated the resident was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses including Ex.Order 26.4(b)(1) [redacted] Review of R1's admission "Minimum Data Set (MDS)" assessment with an Assessment Reference Date (ARD) of Ex.Order 26.4(b)(1) and found in the EMR under the "MDS" tab, indicated a Brief	F 609	F 609: 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. R1 has since been discharged from the facility. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All recorded injuries of unknown origin will be reviewed and any found not to have been reported to the New Jersey Department of Health will be reported.	

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F 609	Continued From page 2 Interview for Mental Status (BIMS) score Ex.Order 26.4(b) out of 15 which indicated R1 had Ex.Order 26.4(b)(1) [redacted]. The assessment indicated the resident exhibited Ex.Order 26.4(b)(1) [redacted] on one to three days of the assessment reference period. The assessment also indicated the resident Ex.Order 26.4(b)(1) [redacted] Review of R1's "Nursing Progress Note," dated Ex.Order 26.4(b)(1) and found in the EMR under the "Notes" tab, revealed "At 1 pm when I went to hand [hang] the Ex.Order 26.4(b)(1) [redacted]] I notice(d) pt [patient] Ex.Order 26.4(b)(1) [redacted] OMD [On-Call Medical Doctor] notified new or send to ER [Emergency Room] for eval [evaluation] Family notified at 1:45 (PM) pt [patient] resident left the building." Documentation related to the reporting of R1's Ex.Order 26.4(b)(1) was requested by the survey team on 01/24/24 at 3:30 PM, however the facility was not able to produce any documentation to show the required reporting had been done. During an interview with the Director of Nursing (DON), the Administrator, and the Infection Preventionist/Wound Care Nurse (IP/WCN) on 01/25/24 at 11:46 AM, the DON and the Administrator stated they were not employed at the facility at the time of the incident. The IP/WCN stated she was familiar with R1 and was in charge of the unit R1 lived on while residing in the facility. She stated the resident went to the local Emergency Department and then did not return to the facility after being transferred to the	F 609	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing or designee will audit all incident reports weekly for 3 weeks and monthly for 3 months thereafter to ensure that all recorded injuries of unknown origin will be reviewed and any found not to have been reported to the New Jersey Department of Health will be reported. Results of the Audits will be forwarded to the Administrator for review by the facility quality assurance committee. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The facility quality assurance committee will review the above mentioned audits and monitor for any trends and update interventions as needed quarterly for 3 quarters.	

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F 609	Continued From page 3 hospital. She confirmed the resident's Ex.Order 26.4(b)(1) [redacted] had not been reported to the State Agency, the local Ombudsman, the resident's representative, local law enforcement, or Adult Protective Services (APS). The DON stated her expectation was R1's Ex.Order 26.4(b)(1) [redacted] should have been immediately reported to all relevant agencies, including the State Agency, the Ombudsman, and the resident's responsible party. The facility's policy titled, "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Policy," dated 09/22, read, in pertinent part, "All reports of abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management Findings of all investigations are documented and reported;" and "The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility, b. The local/state ombudsman, c. The resident's representative, d. Adult protective services (where state law provides jurisdiction in long-term care), e. Law enforcement officials, f. The resident's attending physician, and g. The facility medical director." NJAC 8:39-9.4 (f), 13.1 (c), (d)	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse,	F 610		2/2/24

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F 610	Continued From page 4 neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: C#: NJ00169205, NJ00162219 Based on record review, staff interviews, and facility policy review, the facility failed to ensure a thorough investigation was conducted related to injuries of unknown origin for two of eleven residents (Residents (R) 1 and R4) reviewed for abuse of 21 sample residents. R1 experienced an Ex.Order 26.4(b)(1) and R4 had Ex.Order 26.4(b)(1) these incidents were not investigated by the facility. Findings include: 1. Review of R1's "Admission Record," dated Ex.Order 26.4(b)(1) found in the electronic medical record (EMR) under the "Admissions" tab, indicated the resident was admitted to the facility on Ex.Order 26.4(b)(1) with diagnoses including Ex.Order 26.4(b)(1) [redacted]. Review of R1's admission "Minimum Data Set	F 610	F610: 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Incident reports and investigations into the incidents involving R1 & R4 have both been completed. Both R1 and R4 have since been discharged from the facility. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 610	Continued From page 5 (MDS)" assessment with an Assessment Reference Date (ARD) of Ex.Order 26.4(b)(1) and found in the EMR under the "MDS" tab, indicated a Brief Interview for Mental Status (BIMS) score Ex.Order 26.4(b) out of 15 which indicated R1 had Ex.Order 26.4(b)(1) . The assessment indicated the resident exhibited Ex.Order 26.4(b)(1) ays of the assessment reference period. The assessment also indicated the resident required Ex.Order 26.4(b)(1) Review of R1's "Nursing Progress Note," dated Ex.Order 26.4(b)(1) and found in the EMR under the "Notes" tab, revealed " At 1 pm when I went to hand Ex.Order 26.4(b)(1)] I notice(d) pt [patient] Ex.Order 26.4(b)(1) OMD [On-Call Medical Doctor] notified new or send to ER [Emergency Room] for eval [evaluation]. Family notified at 1:45 (PM) pt [patient] resident left the building." Documentation related to an incident report or an investigation into the potential cause of the injury of unknown origin was requested by the survey team on 01/24/24 at 3:30 PM, however the facility was not able to produce any documentation to show an incident report had been initiated or an investigation of the incident had been done to rule out potential abuse/neglect. During an interview with the Director of Nursing (DON), the Administrator, and the Infection Preventionist/Wound Care Nurse (IP/WCN) on 01/25/24 at 11:46 AM, the DON and the Administrator stated they were not employed at the facility at the time of the incident. The	F 610	All recorded injuries of unknown origin will be reviewed and any found not to have been thoroughly investigated will have a thorough investigation conducted. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing or designee will audit all incident reports weekly for 3 weeks and monthly for 3 months thereafter to ensure that all recorded injuries of unknown origin will be reviewed any found not to have been thoroughly investigated will have a thorough investigation conducted. Results of the Audits will be forwarded to the Administrator for review by the facility quality assurance committee. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The facility quality assurance committee will review the above mentioned audits and monitor for any trends and update interventions as needed quarterly for 3 quarters.	

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F 610	Continued From page 6	F 610		

IP/WCN stated she was familiar with R1 and was in charge of the unit R1 lived on while residing in the facility. She stated the resident went to the local Emergency Department and then did not return to the facility after being transferred to the hospital. She confirmed no incident report had been done related to the resident's Ex.Order 26.4(b)(1) and the incident had not ever been investigated to rule out potential abuse. The DON stated her expectation was any Ex.Order 26.4(b)(1) should be thoroughly investigated and staff and residents (including the subject of the allegation as well as other interviewable residents who might have been subjected to potential abuse/may have knowledge of the incident) were to be interviewed.

2. Review of the "discharge record" found under the "Progress Notes" tab in the EMR for R4 revealed an admission date on Ex.Order 26.4(b)(1) for Ex.Order 26.4(b)(1) .

Review of the admission report indicated R4 was Ex.Order 26.4(b)(1)

Review of the initial "nursing assessment" provided by the facility dated Ex.Order 26.4(b)(1) indicated R4 was oriented to self, Ex.Order 26.4(b)(1)

Review of R4's "Diagnosis" tab located in the EMR revealed diagnoses which included Ex.Order 26.4(b)

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F 610	Continued From page 7	F 610		

Ex.Order 26.4(b)(1) [redacted]

Review of R4's "Progress Notes" tab located in the EM, dated [redacted] at 12:11 PM, revealed R4 was found in bed to have Ex.Order 26.4(b)(1) [redacted] at 9:30 AM.

Review of "Nursing Notes" located in the EMR, dated [redacted] revealed it was reported at 9:14 PM Ex.Order 26.4(b)(1) [redacted] " The [redacted] was completed at the facility. R4 was sent to the emergency department for further evaluation.

Review of an "IDT [Interdisciplinary Team] Note" located in the EMR, dated [redacted], indicated an additional Ex.Order 26.4(b)(1) [redacted] The resident was discharged on [redacted]

Review of the incident report dated [redacted] yielded no interviews or documentation related to an investigation other than the resident [redacted]. Further review and indicated the incident was reported to the state health department as Ex.Order 26.4(b)(1) [redacted] and that one nurse and two nurse aides were interviewed, one of which was interviewed on [redacted]

During an interview on 01/25/24 at 3:05 PM, the Administrator and DON stated that no residents were interviewed from the unit or other units as to what they might have seen on [redacted] or

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F 610	Continued From page 8	F 610		

Ex.Order 26.4(b)(1) Ex.Order 26.4(b)(1). Five additional staff worked with R4 on Ex.Order 26.4(b)(1) night shift and the next morning prior to the incident being reported. The five staff were not interviewed by the facility. No body checks were done on dependent residents living in the same assignment area as the R4.

Review of an "IDT meeting" note found in the EMR under the "Progress Notes" tab dated Ex.Order 26.4(b)(1), indicated that the resident Ex.Order 26.4(b)(1) There was no mention of how Ex.Order 26.4(b)(1)

Review of the facility's policy titled, "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating Policy," dated 09/22, read, in pertinent part, "All reports of abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management Findings of all investigations are documented and reported;" and "All allegations are thoroughly investigated. The administrator initiates investigations."

NJAC 8:39-4.1 a(5)
NJAC 8:39-27.1

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	060222	A. BUILDING: _____ B. WING _____	C 01/26/2024

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S 000	Initial Comments Complaint #: NJ00162219, NJ00165179, NJ00165673, NJ00169205, NJ00152877, NJ00154769, NJ00156006, NJ00158089, NJ00160103, NJ00160808, NJ00161165, and NJ00165678 Survey Dates: 01/24/24 through 01/26/24 Survey Census: 167 Sample Size: 21 The facility is 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: Complaint #: NJ00162219, NJ00165179, NJ00165673, NJ00169205, NJ00152877, NJ00154769, NJ00156006, NJ00158089, NJ00160103, NJ00160808, NJ00161165, and NJ00165678 Based on review of pertinent facility	S 560	S560: 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.	2/2/24

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

Electronically Signed | 02/16/24

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S 560	Continued From page 1 documentation, it was determined that the facility failed to ensure staffing ratios were met to maintain the required minimum staff-to-resident ratios as mandated by the state of New Jersey for 33 of 35 day shifts and 13 of 35 overnight shifts as follows: This deficient practice had the potential to affect all residents. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified as N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio (s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer of all staff members shall be CNAs and each direct staff member shall be signed into work as a certified nurse aide and shall perform nurse aide duties: and one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the 5 weeks of staffing from 03/05/2023 to 03/11/2023, 06/25/2023 to 07/01/2023, 11/12/2023 to 11/18/2023, and 2 weeks of staffing from 01/07/2024 to 01/20/2024, the staffing to resident ratios did not meet the minimum requirement of one CNA to eight residents for the day shift and one direct care staff member to every 10 residents for the	S 560	For periods of cited staffing reports - no residents were negatively affected based on CNA staffing deficiency. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. For those residents identified during the CNA staffing deficiency report dates none were negatively affected by this deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Street facing signage advertising vacancies for RN's LPN's & CNA's will be posted prominently on facility's premises. Increased Salary rates for RN's LPN's & CNA's Sign-on Bonuses will be offered for RN's LPN's & CNA's Recruitment incentive program for all current employees who refer RN's LPN's & CNA's Facility will sponsor CNA school for suitable CNA candidates and hire as hospitality aides during CNA course Administrator or designee will screen appropriate applicants and schedule for interview with the Director of Nursing or designee. Licensed Practical Nurses will work as C.N.A. to meet the C.N.A staffing ratios when staffing permits. The Administrator or designee will review	

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CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

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S 560	Continued From page 2 evening shift as documented below: 1. For the week of Complaint staffing from 03/05/2023 to 03/11/2023, the facility was deficient in CNA staffing for residents on 5 of 7 day shifts as follows: -03/05/23 had 17 CNAs for 170 residents on the day shift, required at least 21 CNAs. -03/06/23 had 18 CNAs for 169 residents on the day shift, required at least 21 CNAs. -03/07/23 had 18 CNAs for 169 residents on the day shift, required at least 21 CNAs. -03/09/23 had 17 CNAs for 167 residents on the day shift, required at least 21 CNAs. -03/10/23 had 19 CNAs for 167 residents on the day shift, required at least 21 CNAs. 2. For the week of Complaint staffing from 06/25/2023 to 07/01/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 6 of 7 overnight shifts as follows: -06/25/23 had 11 CNAs for 176 residents on the day shift, required at least 22 CNAs. -06/25/23 had 11 total staff for 176 residents on the overnight shift, required at least 13 total staff. -06/26/23 had 14 CNAs for 176 residents on the day shift, required at least 22 CNAs. -06/26/23 had 10 total staff for 176 residents on the overnight shift, required at least 13 total staff. -06/27/23 had 14 CNAs for 176 residents on the day shift, required at least 22 CNAs. -06/27/23 had 10 total staff for 176 residents on the overnight shift, required at least 13 total staff. -06/28/23 had 19 CNAs for 176 residents on the day shift, required at least 22 CNAs. -06/29/23 had 17 CNAs for 180 residents on the day shift, required at least 22 CNAs.	S 560	daily census with the Director of Nursing or designee to ensure patient needs can be met based on staffing. The Director of Nursing or designee will review and monitor the staffing daily with staffing coordinator to ensure the facility is meeting mandatory staffing standards 3 weeks and weekly for 3 months thereafter. Results of audits will be forwarded to administrator for review by facility Quality Assurance Committee. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes. The facility quality assurance committee will review the above mentioned audits and monitor for any trends and update interventions as needed quarterly for 3 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060222	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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	S 560		

-06/29/23 had 11 total staff for 180 residents on the overnight shift, required at least 13 total staff.
-06/30/23 had 17 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-06/30/23 had 11 total staff for 180 residents on the overnight shift, required at least 13 total staff.
-07/01/23 had 14 CNAs for 180 residents on the day shift, required at least 22 CNAs.
-07/01/23 had 10 total staff for 180 residents on the overnight shift, required at least 13 total staff.

3. For the week of Complaint staffing from 11/12/2023 to 11/18/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 7 of 7 overnight shifts as follows:

-11/12/23 had 16 CNAs for 168 residents on the day shift, required at least 21 CNAs.
-11/12/23 had 11 total staff for 168 residents on the overnight shift, required at least 12 total staff.
-11/13/23 had 15 CNAs for 168 residents on the day shift, required at least 21 CNAs.
-11/13/23 had 10 total staff for 168 residents on the overnight shift, required at least 12 total staff.
-11/14/23 had 15 CNAs for 168 residents on the day shift, required at least 21 CNAs.
-11/14/23 had 11 total staff for 168 residents on the overnight shift, required at least 12 total staff.
-11/15/23 had 17 CNAs for 168 residents on the day shift, required at least 21 CNAs.
-11/15/23 had 10 total staff for 168 residents on the overnight shift, required ay least 12 total staff.
-11/16/23 had 17 CNAs for 169 residents on the day shift, required at least 21 CNAs.
-11/16/23 had 11 total staff for 169 residents on the overnight shift, required at least 12 total staff.
-11/17/23 had 17 CNAs for 169 residents on the day shift, required at least 21 CNAs.
-11/17/23 had 11 total staff for 169 residents on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060222	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 4	S 560		

the overnight shift, required at least 12 total staff.
-11/18/23 had 16 CNAs for 169 residents on the day shift, required at least 21 CNAs.
-11/18/23 had 11 total staff for 169 residents on the overnight shift, required at least 12 total staff.

4. For the 2 weeks of Complaint staffing from 01/07/2024 to 01/20/2024, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts and deficient in total staff for residents on 5 of 14 overnight shifts as follows:

-01/07/24 had 14 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-01/07/24 had 11 total staff for 166 residents on the overnight shift, required at least 12 total staff.
-01/08/24 had 12 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-01/09/24 had 16 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-01/10/24 had 14 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-01/11/24 had 13 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-01/12/24 had 18 CNAs for 166 residents on the day shift, required at least 21 CNAs.
-01/12/24 had 9.5 total staff for 166 residents on the overnight shift, required at least 12 total staff.
-01/13/24 had 16 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-01/13/24 had 10 total staff for 167 residents on the overnight shift, required at least 12 total staff.

-01/14/24 had 12 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-01/14/24 had 9 total staff for 167 residents on the overnight shift, required at least 12 total staff.
-01/15/24 had 16 CNAs for 167 residents on the day shift, required at least 21 CNAs.
-01/16/24 had 15 CNAs for 167 residents on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060222	A. BUILDING: _____ B. WING _____	C 01/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

(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 5 day shift, required at least 21 CNAs. -01/17/24 had 17 CNAs for 166 residents on the day shift, required at least 20 CNAs. -01/18/24 had 16 CNAs for 166 residents on the day shift, required at least 20 CNAs. -01/19/24 had 16 CNAs for 166 residents on the day shift, required at least 20 CNAs. -01/19/24 had 11 total staff for 166 residents on the overnight shift, required at least 12 total staff. -01/20/24 had 16 CNAs for 166 residents on the day shift, required at least 20 CNAs.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315306	A. Building B. Wing	2/20/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

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 F0609 Reg. # 483.12(b)(5)(i)(A)(B)(c)(1)(4) LSC	Correction Completed 02/02/2024	ID Prefix F0610 Reg. # 483.12(c)(2)-(4) LSC	Correction Completed 02/02/2024	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	
1/26/2024	☐ 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
060222 Y1	A. Building B. Wing Y2	2/20/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT NEW MILFORD	800 RIVER ROAD NEW MILFORD, NJ 07646

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 02/02/2024	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 1/26/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			