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

PRINTED: 03/22/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (7) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01</b>		(X3) DATE SURVEY COMPLETED	
		315339	B. WING _		08/13/2019	
NAME OF PROVIDER OR SUPPLIER  CAREONE AT ORADELL				STREET ADDRESS, CITY, STATE, ZIP CODE  600 KINDERKAMACK ROAD  ORADELL, NJ 07649		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
E 000	Initial Comments		E 0	00		
K 000	Appendix Z-Emerger Provider and Supplie Guidance 483.73, Re Care (LTC) Facilities.	equirements for Long Term	K 0	00		
	LIFE SAFETY CODE	E 101:2012				
	MINIMUM LIFE SAFI	COMPLIANCE WITH THE ETY CODE S SURVEYED USING				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATU	JRE	TITLE	(X6) DATE	

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.

**Electronically Signed** 

08/26/2019