STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

(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
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 Complaint #: NJ 156850NJ, 157814NJ, 160833NJ, 162604, NJ 162907, NJ 165146 Survey Date: 9/21/2023 Census: 55 Sample: 15 +3 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Complaint #NJ 160833 Based on observation, interview, and review of pertinent documents, it was determined that the facility failed to communicate the unavailability of medications from the pharmacy to the physician in accordance with professional standards of	F 658	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE? Orders and Medication Administration Records (MARs) were reviewed to ensure all active medications currently available	10/26/23

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

Electronically Signed | 10/03/2023

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F 658	Continued From page 1 practice. This deficient practice was identified for 2 of 18 residents (Resident #16 and #217) reviewed for standards of practice and was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. On 9/8/23 at 10:12 AM, the surveyor observed Resident #16 sitting up in bed watching television. The resident stated to the surveyor he/she had recently missed a few doses of [redacted] NJ Exec Order 26.4b1 The resident further stated they received the [redacted] NJ Exec Order 2, which was a	F 658	in facility and administered as per orders. Attending Providers and pharmacy made aware of missing medication doses. HOW WILL YOU IDENTIFY THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? Any residents with medication orders have the potential to be affected. Staff was in-serviced on "Unavailable Medications" policy, procedure, and proper documentation. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? The primary Nurse will notify the Attending Provider and Supervisor of any medication not available and document in resident's chart. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? (I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?) DON or designee will review records for any missing doses and proper follow-up	

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F 658	Continued From page 2 long-acting medication as well as a NJ Exec Order 26.4b1 and if needed additional doses of the NJ Exec Order 26.4b1 for exceptionally NJ Exec Order 26.4b1 The surveyor reviewed the medical record for Resident #16. A review of the Admission Record face sheet reflected the resident was admitted to the facility with diagnoses which included acquired NJ Exec Order 26.4 A review of the admission Minimum Data Set (MDS), an assessment tool dated NJ Exec Order 26, reflected a brief interview for mental status (BIMS) score of NJ Exec out of 15, which indicated a NJ Exec Order 26.4b1. A further review reflected the resident received NJ Exec Order 26.4b1. A review of the Order Summary Report (OSR) included a Physician's Order (PO) dated NJ Exec Order 26, for NJ Exec Order 26.4b1 NJ Exec Order 26.4b1 two times a day for NJ Exec Order 26.4b1. A review of the corresponding NJ Exec Order 26.4b1 Medication Administration Record (MAR) revealed the 9:00 AM NJ Exec Order 26.4b1 was not administered on NJ Exec Orde and NJ Exec Orde. The nurse had recorded a "9" which indicated "other/See nurse notes." A review of the resident's NJ Exec Order 26.4b1 Nursing Progress Notes revealed on NJ Exec Order 2 at 8:39 AM, and NJ Exec Order 2 at 12:38 AM, an administration note for NJ Exec Order 2 indicated the medication was awaiting	F 658	daily for 1 week, three times a week for 2 weeks, and monthly for 2 months. Findings will be reported to the Quality Assurance Performance Improvement Committee.	

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F 658	Continued From page 3	F 658		

pharmacy delivery. There was no documentation that the physician had been notified the resident did not receive their [NJ Exec Order 2] medication because they were awaiting pharmacy delivery.

A review of the corresponding [NJ Exec Order 26.4b1] Medication Administration Record (MAR) revealed the 9:00 AM [NJ Exec Order 26.4b1] was not administered on [NJ Exec Order 2] and [NJ Exec Order 2]. The nurse had recorded a "9" which indicated "other/See nurse notes".

A review of the resident's [NJ Exec Order 26.4b1] Nursing Progress Notes revealed on [NJ Exec Orde] at 9:46 AM, and [NJ Exec Order 2] at 8:37 AM, an administration note for [NJ Exec Order 2] indicated the medication was awaiting pharmacy delivery. There was no documentation that the physician had been notified the resident did not receive their [NJ Exec Order 2] medication because they were awaiting pharmacy delivery.

On 9/15/23 at 12:50 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated the resident had [NJ Exec Order 26.4b] and received both [NJ Exec O] [redacted] for [NJ Exec Order 26.4b1] [redacted]. The LPN stated if a resident did not have medication available, the first thing to do was to call the pharmacy and find out why the medication had not been delivered. Once she knew the reason she would call the physician, make them aware of the delay and ask how to proceed. She further stated the nurse was required to document if they called the pharmacy or the physician if there was a missing medication. The nurse should also let a supervisor know. At that time, the LPN and the surveyor reviewed the [NJ Exec Order 2] and [NJ Exec Order 26.4b1] [NJ Exec O] MAR. The LPN stated a "9" indicated a

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F 658	Continued From page 4	F 658		

nursing note had been triggered and a progress note must be made. The LPN stated she had entered the note awaiting pharmacy delivery but should have also documented the physician had been notified and included their instructions on how to proceed.

On 9/18/23 at 12:32 PM the surveyor interviewed the Director of Nursing (DON) who stated she had reviewed the [NJ Exec Order 26.4b1] and [NJ Exec Order 26.4b1] MAR for the resident and acknowledged there were dates the resident had not received their morning [NJ Exec Order 26.4b1] because the nurse indicated the mediation was unavailable from the pharmacy. The DON stated it was the responsibility of the nurse to know how many doses were left in the [NJ Exec Order 26.4b1] and reorder the medication as needed from the pharmacy. If the resident had not received their medication, the nurse should have documented that they made the physician aware and recorded their response in the nursing progress notes.

On 9/20/23 at 11:20 AM, the surveyor attempted to interview the consultant pharmacist via telephone, left a message, but the consultant pharmacist did not return the call.

On 9/20/23 at 11:33 AM, the surveyor interviewed the resident's physician who stated if a resident was going to miss a dose of medication the nurse was supposed to let them know. The physician further stated they did not remember if he had been notified that the resident had missed any [NJ Exec Order 2] doses.

On 9/21/23 at 10:11 AM, the Licensed Nursing Home Administrator (LNHA), in the presence of the DON and survey team acknowledged that the

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F 658	Continued From page 5	F 658		

facility "obviously had a documentation problem", that they were unable to find any documentation the physician had been made aware of the missing medication and subsequent missed doses of [NJ Exec Order].

A review of the facility's "Miscellaneous Special Medications" policy dated effective February 2019, included... Unavailable Medications...Nursing staff shall: notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available... If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction.

2. On 9/15/23 at 1:50 PM, the surveyor reviewed the closed medical record for Resident #217 who was discharged from the facility.

The surveyor reviewed the medical record for Resident #217.

A review of the Admission Record face sheet reflected the resident was admitted to the facility in [NJ Exec Order 26.4b1] with diagnoses which included [NJ Exec Order 26.4b1].

A review of the Admission Evaluation dated [NJ Exec Order 26.4b1] at 9:21 PM, reflected the resident was [NJ Exec Order 26.4b1].

A review of the OSR included a PO dated [NJ Exec Order 26.4b1], for [NJ Exec Order 26.4b1]

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F 658	Continued From page 6 NJ Exec O; give 1 tablet by mouth two times a day every Tuesday, Thursday, Saturday and Sunday for NJ Exec Order 26.4b1, 9:00 AM and 5:00 PM. A review of the corresponding NJ Exec Order 26.4b1 MAR revealed the first scheduled dose for NJ Exec Order 26.4 was 5:00 PM on NJ Exec Order 2. There was no dose scheduled for 9:00 AM on NJ Exec Order 2. As a result, the resident did not receive their morning dose. On 9/20/23 at 10:50 AM, the surveyor interviewed the DON who stated the resident was admitted to the facility after 9:00 PM on NJ Exec Order 2. The resident's NJ Exec Order 26.4 was started on NJ Exec Order 2 at 5:00 PM. The DON stated the resident should have received a dose of NJ Exec Order 26.4 at 9:00 AM on NJ Exec Order 2 but did not because it was not available from the pharmacy. The DON stated there was no documentation that the physician was made aware the resident did not receive a dose of NJ Exec Order 26.4 on NJ Exec Order 2 at 9AM. On 9/20/23 at 11:20 AM, the surveyor attempted to interview the consultant pharmacist via telephone, left a message, but the consultant pharmacist did not return the call. On 09/20/23 at 11:20 AM, the surveyor interviewed the Licensed Practical Nurse weekend supervisor (LPN/WS) who admitted the resident to the facility who stated the process was to verify the medication with the physician, enter the orders and if something was unavailable notify the physician and document that in the medical record. The LPN/WS could not recall the resident and was unsure if she had documented the physician was notified.	F 658		

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F 658	Continued From page 7 On 9/20/23 at 11:33 AM, the surveyor interviewed the resident's physician who stated the nurse was supposed to notify him if there was a medication that was unavailable from the pharmacy. The physician could not recall the resident and was unsure if he had been notified of the resident missing their first dose of [redacted NJ Exec Order 26.4b]. A review of the facility's "Miscellaneous Special Medications" policy dated effective February 2019, included... Unavailable Medications...Nursing staff shall: notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available... If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction. NJAC 8:39-11.2(b); 27.1(a)	F 658		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812		10/26/23

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F 812	Continued From page 8 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to store, label, and date potentially hazardous foods to prevent food-borne illnesses. This deficient practice was evidenced by the following: On 09/08/2023 at 9:30 AM, the surveyor, in the presence of the Food Service Director (FSD), toured the kitchen and observed the following: 1. In the dry storage room, there was a 2-pound bag of dry roasted sea salt peanuts that was wrapped in clear plastic with a label with an opened date of 07/12/23 and used by 07/25/23. The FSD discarded them. 2. In the reach-in freezer, there was a 5 lb. bag of cheese medium-squared ravioli that was opened and wrapped in clear plastic not labelled or dated. The FSD discarded them. 3. In the reach-in refrigerator, there was a ¼ metal pan size pan of potato salad dated 09/04/23 with a used by date of 09/06/23. The FSD discarded it. On 09/08/23 at 11:30 AM, the surveyor met with the FSD who stated food that were opened, repacked, should be labeled and dated with an	F 812	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE? There were no patients identified that were affected by the deficient practice. All food items were inspected for proper labels and dates. All items not properly labeled and dated were discarded. HOW WILL YOU IDENTIFY THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? All residents being served from the kitchen have the potential to be affected. All Dietary staff in-serviced on proper labeling and dating policy and procedure. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? All food items are to be labeled with an "open" and "use by" date generated from	

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F 812	Continued From page 9 opened and used by date. The FSD stated that food that were opened and repacked in refrigerator/ freezer should be labeled and dated with an opened date and a used by date. The FSD stated food should be labeled and dated and used before the used by date so that the residents would not get sick. On 09/20/23 12:27 PM, the surveyors met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) and were informed of the findings. A review of the facility's policy "Food Receiving and Storage Policy" with a revised date of November 2022, indicated dry foods that are stored in bins are removed from original packaging, labeled and dated ("use by" date) and all foods stored in the refrigerator or freezer are covered, labeled and dated ("use by" date). Refrigerated foods are labeled, dated and monitored so they are used by their "use-by" date, frozen or discarded". NJAC 8:39-17.2(g)	F 812	the Daymark system set up to meet FDA and ServeSafe standards. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? (I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?) The Culinary Services Director or designee will audit daily for 2 weeks, three times a week for 2 weeks, and monthly for 2 months to ensure compliance. Findings will be presented to the Quality Assurance Performance Improvement Committee.	

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: 1.Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "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 at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE? The leadership team continues to monitor and discuss challenges and areas of improvement for nursing staffing needs. HOW WILL YOU IDENTIFY THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? All residents have the potential to be affected.	10/26/23

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

Electronically Signed | 10/03/23

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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 2/01/21: 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 than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA 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. A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report for the weeks of 07/10/2022 to 07/23/2022, 08/28/2022 to 09/10/2022, 01/08/2023 to 01/21/2023, 03/19/2023 to 03/25/2023, 06/18/2023 to 06/24/2023, and 08/27/2023 to 09/09/2023 revealed the facility was deficient in CNA staffing for residents as follows: For the 2 weeks of staffing from 07/10/2022 to 07/23/2022, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -07/10/22 had 4 CNAs for 45 residents on the day shift, required at least 6 CNAs. -07/11/22 had 4 CNAs for 41 residents on the day shift, required at least 5 CNAs. -07/12/22 had 4 CNAs for 40 residents on the day shift, required at least 5 CNAs. -07/13/22 had 4 CNAs for 40 residents on the day	S 560	WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? The Center has implemented significant above market rates for certified nursing aides. Other incentives include tuition reimbursement, sign-on and employee referral bonus programs, and paid training if not certified. The Center promotes paid sponsorship campaigns to advertise open positions and has secured paid Indeed membership to proactively seek and establish direct contact with potential candidates. The Center continues to expedite contingency offers at the time of interview. The Center continues to coordinate supplemental assistance from other non-CNA staff where appropriate, including non-clinical assistance and Therapy assignments to assist with ADLs. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? (I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?) The Director of Nursing or designee will monitor the certified nursing aide staffing ratios daily and document a weekly review of the daily staffing for 4 weeks then twice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061810	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 560	Continued From page 2 shift, required at least 5 CNAs. -07/14/22 had 4 CNAs for 40 residents on the day shift, required at least 5 CNAs. -07/15/22 had 4 CNAs for 40 residents on the day shift, required at least 5 CNAs. -07/16/22 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -07/17/22 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -07/19/22 had 5 CNAs for 54 residents on the day shift, required at least 7 CNAs. -07/20/22 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -07/21/22 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. -07/22/22 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. -07/23/22 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. For the 2 weeks of staffing from 08/28/2022 to 09/10/2022, the facility was deficient in CNAs staffing for residents on 13 of 14 day shifts as follows: -08/28/22 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -08/29/22 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -08/31/22 had 5 CNAs for 50 residents on the day shift, required at least 6 CNAs. -09/01/22 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. -09/02/22 had 6 CNAs for 57 residents on the day shift, required at least 7 CNAs. -09/03/22 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -09/04/22 had 5 CNAs for 56 residents on the day shift, required at least 7 CNAs. -09/05/22 had 6 CNAs for 56 residents on the day	S 560	monthly for two months. The audits will be presented to the Administrator. The DON or designee will present the results to the Quality Assurance Performance Improvement Committee for review. The Committee will review and revise the plan if needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061810	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

(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		

shift, required at least 7 CNAs.
-09/06/22 had 4 CNAs for 56 residents on the day shift, required at least 7 CNAs.
-09/07/22 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs.
-09/08/22 had 3 CNAs for 57 residents on the day shift, required at least 7 CNAs.
-09/09/22 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs.
-09/10/22 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs.

For the 2 weeks of staffing from 01/08/2023 to 01/21/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows:

-01/08/23 had 6 CNAs for 61 residents on the day shift, required at least 8 CNAs.
-01/09/23 had 6 CNAs for 60 residents on the day shift, required at least 7 CNAs.
-01/10/23 had 5 CNAs for 59 residents on the day shift, required at least 7 CNAs.
-01/11/23 had 6 CNAs for 59 residents on the day shift, required at least 7 CNAs.
-01/12/23 had 4 CNAs for 59 residents on the day shift, required at least 7 CNAs.
-01/13/23 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs.
-01/14/23 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs.
-01/15/23 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs.
-01/16/23 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs.
-01/17/23 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs.
-01/18/23 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs.
-01/19/23 had 5 CNAs for 61 residents on the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061810	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

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S 560	Continued From page 4 shift, required at least 6 CNAs. -01/20/23 had 5 CNAs for 59 residents on the day shift, required at least 7 CNAs. -01/21/23 had 5 CNAs for 59 residents on the day shift, required at least 7 CNAs. For the week of staffing from 03/19/2023 to 03/25/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts as follows: -03/19/23 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs. -03/20/23 had 5 CNAs for 57 residents on the day shift, required at least 7 CNAs. -03/21/23 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs. -03/22/23 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -03/23/23 had 4 CNAs for 51 residents on the day shift, required at least 6 CNAs. -03/24/23 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. -03/25/23 had 5 CNAs for 48 residents on the day shift, required at least 6 CNAs. For the week of staffing from 06/18/2023 to 06/24/2023, the facility was deficient in CNA staffing for residents on 7 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -06/18/23 had 6 CNAs for 58 residents on the day shift, required at least 7 CNAs. -06/19/23 had 4 CNAs for 56 residents on the day shift, required at least 7 CNAs. -06/19/23 had 3 total staff for 56 residents on the overnight shift, required at least 4 total staff. -06/20/23 had 4 CNAs for 54 residents on the day shift, required at least 7 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061810	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

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S 560	Continued From page 5 -06/21/23 had 5 CNAs for 54 residents on the day shift, required at least 7 CNAs. -06/22/23 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -06/23/23 had 5 CNAs for 49 residents on the day shift, required at least 7 CNAs. -06/24/23 had 5 CNAs for 48 residents on the day shift, required at least 7 CNAs. For the 2 weeks of staffing prior to survey from 08/27/2023 to 09/09/2023, the facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows: -08/27/23 had 4 CNAs for 49 residents on the day shift, required at least 6 CNAs. -08/28/23 had 4 CNAs for 49 residents on the day shift, required at least 6 CNAs. -08/29/23 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -08/30/23 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -08/31/23 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. -09/01/23 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs. -09/02/23 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs. -09/03/23 had 5 CNAs for 55 residents on the day shift, required at least 7 CNAs. -09/04/23 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -09/05/23 had 4 CNAs for 56 residents on the day shift, required at least 7 CNAs. -09/06/23 had 5 CNAs for 53 residents on the day shift, required at least 7 CNAs. -09/07/23 had 4 CNAs for 53 residents on the day shift, required at least 7 CNAs. -09/08/23 had 4 CNAs for 53 residents on the day shift, required at least 7 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061810	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

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S 560	Continued From page 6 -09/09/23 had 4 CNAs for 53 residents on the day shift, required at least 7 CNAs. During an interview with a surveyor on 09/20/23 at 10:09 AM, the Staffing Coordinator stated that they were familiar with minimum staffing ratio requirements. During an interview with the surveyor on 09/20/23 at 12:22 PM, the Licensed Nursing Home Administrator stated that they were also aware of the minimum staffing ratio requirements.	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)
315002	A. Building B. Wing	10/30/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 10/26/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315002		10/30/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

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 F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 10/26/2023	ID Prefix F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 10/26/2023	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/21/2023	☐ 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
061810 Y1	A. Building B. Wing Y2	10/30/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

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 10/26/2023	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 9/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

 EVENT ID: V7F612

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	**1621 ROUTE 22 WEST** **BOUND BROOK, NJ 08805**

(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
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 9/21/23, and Care One at Somerset 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 Somerset Valley is a 1-story building that was built in 60's. It is composed of Type I construction. The facility is divided into 6 smoke zones. The 600 KW exterior diesel generator does 100% of the facility. The building also has an assisted living section. The facility has liquid oxygen and utilizes a fire pump to support the fire sprinkler system.	K 000		
K 222 SS=F	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available	K 222		10/2/23

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

Electronically Signed | 10/03/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	**1621 ROUTE 22 WEST** **BOUND BROOK, NJ 08805**

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K 222	Continued From page 1 to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	**1621 ROUTE 22 WEST** **BOUND BROOK, NJ 08805**

(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
K 222	Continued From page 2 by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, in the presence of Maintenance Director (MD) and Regional Plant Operations Director (RPOD) on 9/21/23, it was determined that the facility failed to provide exit doors in the means of egress readily accessible and free of all obstructions or impediments to full instant use in the case of fire or other emergencies in accordance with the requirements of NFPA 101, 2012 Edition, Section 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. This deficient practice was identified for 2 of 2 sets of doors and was evidenced as follows: At 11:15 AM, the surveyor, Maintenance Director (MD), and Regional Plant Operations Director (RPOD) observed two sets of glass sliding doors located at the front entrance of the facility. The interior and exit set of sliding doors had a lockset that engaged a hook-type deadbolt. The device on the door could restrict emergency use of the exit. The current evacuation plan indicated that the front doors were designated an exit/egress route. The two-sets of sliding door had signs indicating push to open in an emergency, but with the thumb-latch locks engaged this procedure would not open the doors as stated on the signs. At the time of the observation, the surveyor interviewed the MD and RPOD who stated that the lockset (hook type deadbolt) could restrict use of the exit from the egress-side in the event of an emergency.	K 222	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE? The Main entrance door was inspected and found to be operating properly. The latch and lock from the door were removed. The door was re-inspected and remains in proper operation. HOW WILL YOU IDENTIFY THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? All residents have the potential to be affected. All other exit doors inspected for latch and locking devices. All doors found to be in compliance and operating properly. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? Current as well as all future maintenance staff will be educated on orientation regarding proper means of egress.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	**1621 ROUTE 22 WEST** **BOUND BROOK, NJ 08805**

(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
K 222	Continued From page 3 The Administrator and Regional Plant Operations Director were notified of the findings at the Life Safety Code Exit Conference on 9/21/23. NJAC 8:39-31.2(e) NFPA 101, 2012 Edition, Section - 19.2.2.2.5.1, 19.2.2.2.5.2 and 19.2.2.2.6. NFPA 101:2012 Edition, Section - 7.2.1.6.1.1(3)C	K 222	HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? (I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?) All egress doors to be inspected for proper operation weekly for 4 weeks. Findings will be presented to the Quality Assurance Performance Improvement Committee for review.	
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		10/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	**1621 ROUTE 22 WEST** **BOUND BROOK, NJ 08805**

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review, on 9/21/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to ensure that 1 of 1 kitchen ansul system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10. The deficient practice was evidenced by the following: At 11:27 AM, the surveyor, RPOD and MD observed in the kitchen, that the monthly inspection tag to the ansul fire suppression system, was blank and no required monthly inspection of the ansul system was logged, since the facility vendor completed the annual inspection of the system. At that time, the surveyor interviewed the MD and RPOD, who both confirmed that the ansul monthly inspection tag was not completed and left blank. The Administrator and Regional Plant Operations Director were informed of the deficiency at the Life Safety Code exit conference on 9/21/23. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE? The ANSUL fire suppression system was inspected and found to be in operating order. The month and date of the inspection was properly documented. HOW WILL YOU IDENTIFY THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? All residents have the potential to be affected. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? Log created for location of fire suppression system pull station in kitchen. Maintenance staff will round monthly and record results. Current as well as all new future maintenance staff will be educated on hire on location and inspection process for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING **01** B. WING _____	**09/21/2023**

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K 324	Continued From page 5	K 324	kitchen suppression system. HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? (I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?) Maintenance Director or designee will audit monthly for three months to ensure compliance. Findings will be presented to the Quality Assurance Performance Improvement Committee for review.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		10/2/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	**1621 ROUTE 22 WEST** **BOUND BROOK, NJ 08805**

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K 353	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on surveyor observation and interview on 9/21/23, in the presence of the Regional Plant Operations Director (RPOD) and Maintenance Director (MD), it was determined that the facility failed to maintain all parts of their automatic sprinkler system in optimal condition as per section 5.2.1.1.1 of National Fire Prevention Association (NFPA) 25. The deficient practice was for 2 of 2 fire sprinkler cabinets, and was evidenced by the following: At 1:32 PM, the surveyor, RPOD and MD observed 2 of 2 fire sprinkler cabinets in the fire sprinkler room. The two (2) red cabinets were observed to have (12) extra fire sprinkler heads, but did not have the required wrench to change the sprinkler heads in the event of an activation. An interview was conducted with the RPOD and MD during the observations, where the RPOD and MD confirmed the above findings. The Administrator and Regional Plant Operations Director were informed of the finding's at the Life Safety Code exit conference on 9/21/23. NJAC 8:39 - 31.1(c), 31.2(e) NFPA 13, 25	K 353	WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS AFFECTED BY THE DEFICIENT PRACTICE? Two sprinkler wrenches were placed in the fire sprinkler room. HOW WILL YOU IDENTIFY THOSE RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN? All residents have the potential to be affected. Maintenance staff were educated that sprinkler head wrenches must be designated to the sprinkler room/returned when not in use. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES YOU WILL MAKE TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? Maintenance staff will round weekly to ensure sprinkler wrenches are present and record findings. Current as well as all future maintenance staff will be educated on proper procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING **01** B. WING _____	**09/21/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 7	K 353	HOW THE CORRECTIVE ACTIONS WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR? (I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE?) Maintenance Director or designee will perform sprinkler room wrench audit daily for 1 week, weekly for 2 weeks, and monthly for 2 months to ensure compliance. Findings will be presented to the Quality Assurance Performance Improvement Committee for review.	

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)
315002	A. Building 01 - MAIN BUILDING 01 B. Wing	10/30/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

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 Reg. # NFPA 101 LSC K0222	Correction Completed 10/02/2023	ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 10/02/2023	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 10/02/2023
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 9/21/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			