STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315152	A. BUILDING ______ B. WING ______	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET** **HACKENSACK, NJ 07601**

(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 Complaint # NJ00165718 Census: 98 Sample Size: 4 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		

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

Electronically Signed — 08/25/2023

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.

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060205	A. BUILDING: ______ B. WING ______	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET HACKENSACK, NJ 07601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments C #: NJ00165718 Census: 98 Sample Size: 4 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: Based on facility document review on 07/20/23, 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 14 of 14 day shifts and 3 of 14 evening shifts reviewed. This deficient practice had the potential to affect all residents. Findings include:	S 560	S506 What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility leadership team has met a ongoing basis and continues to identify staffing challenges and areas of	8/25/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/25/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060205	A. BUILDING: ____ B. WING ____	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET HACKENSACK, NJ 07601**

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S 560	Continued From page 1 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 at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. 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. 1. A review of the "Nurse Staffing Report" completed by the facility for the weeks of 07/02/23 to 07/08/23 and 07/09/23 to 07/15/23 revealed the staffing to resident ratios did not meet the minimum requirement. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts, and was deficient in CNAs to total staff on 3 of 14 evening shifts as followed: -07/02/23 had 7 CNAs for 97 residents on the day shift, required 12 CNAs.	S 560	improvement for certified nursing assistant staffing needs How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the capacity to be affected and corrective actions will be extended to all residents. What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur. The facility has implemented a significant above market rates for nurses and certified nursing assistants. The facility has implemented an incentive program including referral bonuses for employees referring staff where appropriate. The facility continues to conduct ongoing job fairs, internally and externally with immediate interviews. The Facility implemented an expedited onboarding process to new hires. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur, i.e what program will be put into place to monitor the continued effectiveness of the systemic changes. The Director of Nursing/and or designee meets with staffing coordinator daily to	

New Jersey Department of Health

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	060205	A. BUILDING: ______ B. WING ______	C 07/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	**301 UNION STREET HACKENSACK, NJ 07601**

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S 560	Continued From page 2 -07/03/23 had 7 CNAs for 97 residents on the day shift, required 12 CNAs. -07/03/23 had 5 CNAs to 14 total staff on the evening shift, required 7 CNAs. -07/04/23 had 11 CNAs for 97 residents on the day shift, required 12 CNAs. -07/05/23 had 10 CNAs for 97 residents on the day shift, required 12 CNAs. -07/06/23 had 9 CNAs for 98 residents on the day shift, required 12 CNAs. -07/07/23 had 8 CNAs for 97 residents on the day shift, required 12 CNAs. -07/08/23 had 6 CNAs for 95 residents on the day shift, required 12 CNAs. -07/09/23 had 6 CNAs for 95 residents on the day shift, required 12 CNAs. -07/10/23 had 6 CNAs for 95 residents on the day shift, required 12 CNAs. -07/11/23 had 7 CNAs for 94 residents on the day shift, required 12 CNAs. -07/12/23 had 8 CNAs for 94 residents on the day shift, required 12 CNAs. -07/12/23 had 5 CNAs to 12 total staff on the evening shift, required 6 CNAs. -07/13/23 had 8 CNAs for 94 residents on the day shift, required 12 CNAs. -07/13/23 had 6 CNAs to 14 total staff on the evening shift, required 7 CNAs. -07/14/23 had 11 CNAs for 94 residents on the day shift, required 12 CNAs. -07/15/23 had 7 CNAs for 98 residents on the day shift, required 12 CNAs.	S 560	review facility census, call outs if any, and staffing needs. The Director Of Nursing/and or designee will monitor call outs and staffing ratios weekly until the requirement is met The results of the audits will be forwarded to the facility Administrator and Quality Assurance Improvement Committee for further review and recommendations as needed x 2 quarters.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
060205		8/31/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT WELLINGTON	301 UNION STREET HACKENSACK, NJ 07601

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 08/25/2023	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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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
7/20/2023	