	-	ID HUMAN SERVICES			FO	RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		``'	ATE SURVEY
		315306	B. WING			C 01/26/2024
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAREONE	E AT NEW MILFORD			800 RIVER ROAD NEW MILFORD, NJ 07646		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	0		
	A Complaint Survey the New Jersey Depa	was conducted on behalf of artment of Health.				
	Complaint #: NJ0016 NJ00165673, NJ0016 NJ00154769, NJ0015 NJ00160103, NJ0016 NJ00165678.	69205, NJ00152877,				
	Survey Dates: 01/24/	24 through 01/26/24				
	Survey Census: 167					
	Sample Size: 21					
	42 CFR PART 483, S	THE REQUIREMENTS OF UBPART B, FOR FACILITIES BASED ON				
F 609 SS=D	1 0 0		F 60	9		2/2/24
		se to allegations of abuse, or mistreatment, the facility				
	involving abuse, negl mistreatment, includin source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not res	ng injuries of unknown priation of resident property, itely, but not later than 2 tion is made, if the events tion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to				
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
Electroni	cally 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.

PRINTED: 04/30/2024

-		D HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/30/2024 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	COMF	E SURVEY PLETED
		315306	B. WING			C /26/2024
NAME OF PROVIDER OR S	UPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	• •	
CAREONE AT NEW MI	LFORD			800 RIVER ROAD NEW MILFORD, NJ 07646		
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
officials (in adult prote for jurisdic accordanc procedures §483.12(c) investigated designated accordanc Survey Ag incident, a appropriate This REQU by: Complaint Based on a facility poli an injury o appropriate eleven res abuse of 2 <b>EX.Order 26</b> reported to the State A Review of indicated t on <b>EXORM 2017</b> Review of (MDS)" as Reference	strator of the cluding to the cetive service tion in long e with State s. (4) Report ons to the a d represent e with State ency, within nd if the all e corrective JIREMENT t #: NJ0016 record revie cy review, f f unknown e entities in idents (Res 1 sample re (Agency. Fin a the local ( Agency. Fin R1's "Admin ind found in (R) under the resident with diag R1's admis sessment v Date (ARE	the facility and to other the State Survey Agency and the swhere state law provides term care facilities) in a law through established the results of all diministrator or his or her ative and to other officials in a law, including to the State to 5 working days of the eged violation is verified the action must be taken. is not met as evidenced	F 609	<ul> <li>F 609:</li> <li>1. How the corrective action will be accomplished for those residents f have been affected by the deficien practice.</li> <li>R1 has since been discharged from facility.</li> <li>2. How the facility will identify oth residents having the potential to be affected by the same deficient practice.</li> <li>All recorded injuries of unknown or be reviewed and any found not to been reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New Jersey Department of Health will be reported to the New</li></ul>	ound to t n the er ectice . rigin will nave	

Event ID: B52D11

Facility ID: NJ60222

If continuation sheet Page 2 of 9

CENTER STATEMENT ( AND PLAN OF NAME OF PI CAREONE (X4) ID PREFIX	S FOR MEDICARE & DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E AT NEW MILFORD SUMMARY ST/ (EACH DEFICIENCT	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315306	A. BUILDING B. WING 8 8 8 8 8 8 8 1D PREFIX	E CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE 00 RIVER ROAD IEW MILFORD, NJ 07646 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL COOP OFFERENCE ACTION SHOUL	ONN DBE	D: 04/30/2024 M APPROVED D. 0938-0391 SURVEY PLETED C (26/2024
TAG F 609	Continued From page Interview for Mental S out of 15 which indica . The asse resident exhibited Ex. three days of the asse The assessment also Ex.Order 26.4(b)( Review of R1's "Nurse Norder 20.4(b)( Review of R1's "Nurse Norder 20.4(b)( Survey team on 01/24 facility was not able to	Attatus (BIMS) score exore 26.4(b) ted R1 had Ex.Order 26.4(b)(1) essment indicated the Order 26.4(b)(1) on one to essment reference period. indicated the resident 1) Ing Progress Note," dated the EMR under the "Notes" in when I went to hand 26.4(b)(1) Itex.Order 26.4(b)(1) OMD tor] notified new or send to n] for eval [evaluation] 5 (PM) pt [patient] resident d to the reporting of R1's Was requested by the /24 at 3:30 PM, however the	F 609	<ul> <li>CROSS-REFERENCED TO THE APPRO DEFICIENCY)</li> <li>3. What measures will be put into por systemic changes made to ensure the deficient practice will not recur.</li> <li>The Director of Nursing or designee audit all incident reports weekly for weeks and monthly for 3 months thereafter to ensure that all recorde injuries of unknown origin will be rev and any found not to have been rep to the New Jersey Department of H will be reported.</li> <li>Results of the Audits will be forward the Administrator for review by the f quality assurance committee.</li> <li>4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected will not recur, i.e. what program will into place to monitor the continued effectiveness of the systemic change</li> </ul>	olace e that will 3 d viewed orted lealth ed to acility and be put	
	(DON), the Administra Preventionist/Wound 01/25/24 at 11:46 AM Administrator stated t the facility at the time IP/WCN stated she w in charge of the unit F the facility. She stated local Emergency Dep	Care Nurse (IP/WCN) on , the DON and the hey were not employed at		The facility quality assurance comm will review the above mentioned aud and monitor for any trends and upda interventions as needed quarterly for quarters.	dits ate	

Facility ID: NJ60222

If continuation sheet Page 3 of 9

	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	
. 01 0	SINCONON	DENTIFICATION NOWDER.	A. BUILDING	3	COMPL	
		315306	B. WING			6/2024
F PRC	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
DNE A	AT NEW MILFORD			800 RIVER ROAD NEW MILFORD, NJ 07646		
x	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
09	Continued From page	e 3	F 60	19		
	nospital. She confirm		1.00			
	had n	not been reported to the				
	State Agency, the loc					
	•	tive, local law enforcement, ervices (APS). The DON				
	stated her expectation	n was R1's				
		d have been immediately				
	eported to all relevar State Agency, the On	nt agencies, including the				
	resident's responsible					
-	The facility's policy tit	led, "Abuse, Neglect,				
		propriation - Reporting and				
	nvestigating Policy,"	dated 09/22, read, in				
		ports of abuse (including rigin), neglect, exploitation,				
		tion of resident property are				
		e and federal agencies (as				
		egulations) and thoroughly y management Findings of				
		documented and reported;"				
á	and "The administrate	or or the individual making				
		iately reports his or her				
	The state licensing/ce	ving persons or agencies: a.				
	-	ying/licensing the facility, b.				
		dsman, c. The resident's				
	•	ult protective services vides jurisdiction in long-term				
	care), e. Law enforce					
	esident's attending p nedical director."	hysician, and g. The facility				
1	NJAC 8:39-9.4 (f), 13	8.1 (c), (d)				
	nvestigate/Prevent/C CFR(s): 483.12(c)(2)	Correct Alleged Violation -(4)	F 61	10	2	2/2/24
10 I =D (	NJAC 8:39-9.4 (f), 13 nvestigate/Prevent/C CFR(s): 483.12(c)(2)-	Correct Alleged Violation	F 61	10		:

Facility ID: NJ60222

If continuation sheet Page 4 of 9

	-	D HUMAN SERVICES MEDICAID SERVICES			FORM APPRC OMB NO. 0938-0	OVED
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	5001
		315306	B. WING		C 01/26/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 800 RIVER ROAD NEW MILFORD, NJ 07646		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		TION
F 610	must: §483.12(c)(2) Have e violations are thoroug §483.12(c)(3) Preven neglect, exploitation, i investigation is in pro- §483.12(c)(4) Report investigations to the a designated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: C#: NJ00169205, NJ Based on record revise facility policy review, f thorough investigation injuries of unknown of residents (Residents abuse of 21 sample re <b>EX.Order 26.4(b)(1)</b> and these incidents were a facility. Findings inclu 1. Review of R1's "Ad <b>EX.Order 26.4(b)(1)</b> found in record (EMR) under t	or mistreatment, the facility vidence that all alleged hly investigated. t further potential abuse, or mistreatment while the gress. the results of all administrator or his or her ative and to other officials in e law, including to the State n 5 working days of the eged violation is verified e action must be taken. is not met as evidenced 00162219 ew, staff interviews, and the facility failed to ensure a n was conducted related to rigin for two of eleven (R) 1 and R4) reviewed for esidents. R1 experienced an d R4 had <b>EX.Order 26.4(b)(1)</b> not investigated by the de: mission Record," dated in the electronic medical he "Admissions" tab, was admitted to the facility	F 610	<ul> <li>F610:</li> <li>1. How the corrective action will be accomplished for those residents four have been affected by the deficient practice.</li> <li>Incident reports and investigations into incidents involving R1 &amp; R4 have both been completed.</li> <li>Both R1 and R4 have since been discharged from the facility.</li> <li>2. How the facility will identify other residents having the potential to be</li> </ul>	the	
		noses including sion "Minimum Data Set				

Event ID: B52D11

Facility ID: NJ60222

If continuation sheet Page 5 of 9

PRINTED: 04/30/2024

			()(0) + 11 +			10.0938-039
	OF DEFICIENCIES - CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	. ,	TE SURVEY MPLETED
			A. DOILDING			С
		315306	B. WING		0	1/26/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
	E AT NEW MILFORD			800 RIVER ROAD		
CAREON				NEW MILFORD, NJ 07646		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 610	Continued From page	e 5	F 61	0		
	(MDS)" assessment v					
	Reference Date (ARE	D) of <sup>Ex.Order 26.4(b)(1)</sup> and found in		All recorded injuries of u	unknown origin will	
		MDS" tab, indicated a Brief		be reviewed and any fo		
	Interview for Mental S	Status (BIMS) score <sup>conter</sup> 2040) ated R1 had <mark>Ex.Order 26.4(b)(1)</mark>		been thoroughly investig thorough investigation of		
		essment indicated the		unorougn investigation c	conducted.	
	resident exhibited Ex					
		essment reference period.		3. What measures will		
	required Ex.Order 2	indicated the resident		or systemic changes ma the deficient practice wi		
		20.4(0)(1)				
				The Director of Nursing	or designee will	
		ing Progress Note," dated		audit all incident reports		
		n the EMR under the "Notes"		weeks and monthly for		
	Ex.Order 26.4(b)	m when I went to hand		thereafter to ensure tha injuries of unknown orig		
		Ex.Order 26.4(b)(1)		any found not to have b		
		OMD		investigated will have a		
		tor] notified new or send to		investigation conducted		
		m] for eval [evaluation].				
	left the building."	5 (PM) pt [patient] resident		Results of the Audits wi the Administrator for rev		
	lent the building.			quality assurance com		
	Documentation relate	ed to an incident report or an				
		potential cause of the injury				
	-	s requested by the survey		<b>A 1 1 1 1 1 1 1 1 1 1</b>		
		3:30 PM, however the facility uce any documentation to		4. How the facility will r corrective actions to en		
	·	ort had been initiated or an		deficient practice is beir		
		cident had been done to rule		will not recur, i.e. what	-	
	out potential abuse/ne	eglect.		into place to monitor the		
	During an interview	with the Director of Normalian		effectiveness of the sys	temic changes.	
	-	vith the Director of Nursing ator, and the Infection		The facility quality assu	rance committee	
		Care Nurse (IP/WCN) on		will review the above m		
	01/25/24 at 11:46 AM			and monitor for any trer		
	Administrator stated t	they were not employed at		interventions as needed		
	the facility at the time	of the incident. The		quarters.		

Facility ID: NJ60222

If continuation sheet Page 6 of 9

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/30/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315306	B. WING			_		C <b>26/2024</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CAREON	E AT NEW MILFORD				800 RIVER ROAD NEW MILFORD, NJ 076	46		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	IP/WCN stated she w in charge of the unit F the facility. She stated local Emergency Dep return to the facility af hospital. She confirme been done related to and the incident had n rule out potential abus expectation was any should be thoroughly residents (including th as well as other interviewed. 2. Review of the "disc the "Progress Notes" revealed an admissio <b>Ex.Order 26.4(b)(</b> Review of the admiss <b>Ex.Order 26.4(b)(</b> Review of the initial "r provided by the facilit R4 was oriented to se	as familiar with R1 and was A1 lived on while residing in d the resident went to the artment and then did not the resident report had the resident's xorder 26.4(b)(1) investigated and staff and the subject of the allegation viewable residents who ected to potential wledge of the incident) were tharge record" found under tab in the EMR for R4 in date on xorder 26.4(b)(1) for 1) ion report indicated R4 was 1) mursing assessment" y dated xorder 26.4(b)(1) indicated eff. Ex.Order 26.4(b)(1)	F	610				

Event ID: B52D11

Facility ID: NJ60222

If continuation sheet Page 7 of 9

					FORM	): 04/30/2024 MAPPROVED ). 0938-0391
	· /				(X3) DATE COMP	SURVEY LETED
315306	B. WING					26/2024
		S	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
				5		
IUST BE PRECEDED BY FULL			(EACH CORRECT CROSS-REFERENC	IVE ACTION SHOULD BI ED TO THE APPROPRIA		(X5) COMPLETION DATE
ess Notes" tab located in at 12:11 PM, revealed R4 (e Ex.Order 26.4(b)(1)) ess" located in the EMR, dit was reported at 9:14 ()(1) completed at the facility. ergency department for rdisciplinary Team] Note" (ecs.Order 26.4(b)(1) (), indicated an 6.4(b)(1) () The resident (), indicated an 6.4(b)(1) () () the resident (), indicated an 6.4(b)(1) () () () () () () () () () () () () ()	F	610				
	315306         EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)         SS NOTES" tab located in tat 12:11 PM, revealed R4 (e Ex.Order 26.4(b)(1)         es" located in the EMR, di twas reported at 9:14 ()(1)         es" located in the EMR, di twas reported at 9:14 ()(1)         completed at the facility. argency department for         rdisciplinary Team] Note" (concerection(1), indicated an (6.4(b)(1))         The resident         eport dated         concerection(1)         concerection(1)         concerection(1)         concerection(1)	EDICAID SERVICES         (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILD         315306       B. WING         315306       B. WING         EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL DENTIFYING INFORMATION)       ID PREF TAGE         SS NOTES" tab located in lat 12:11 PM, revealed R4 re <b>EX.Order 26.4(b)(1)</b> F         es" located in the EMR, d it was reported at 9:14 <b>)(1)</b> F         completed at the facility. ergency department for       F         rdisciplinary Team] Note" edeed 5000000000000000000000000000000000	EDICAID SERVICES (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  315306 B. WING  315306 B. WING  C. C	EDICAID SERVICES         (1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A BUILDING         315306       B. WING         315306       B. WING         STREET ADDRESS, CITY, STAT 800 RIVER ROAD NEW MILFORD, NJ 07644         EMENT OF DEFICIENCIES MUST BE PRECIDED BY FULL 10 DENTIFYING INFORMATION)       PRE TA PRE TA TAG         SS Notes" tab located in [at 12:11 PM, revealed R4 re [EX.Order 26.4(D)(1)]       F 610         ses" located in the EMR, d it was reported at 9:14 )(1)       F         completed at the facility. regency department for       The resident         rdisciplinary Team] Note" edisciplinary Team] Note" edistated that no residents he unit or other units as to <td>HUMAN SERVICES EDICAID SERVICES EDICAID SERVICES EDICAID SERVICES EDICAID SERVICES EDICAID SERVICES (2) MULTIPLE CONSTRUCTION A BUILDING 315306 B. WING STREET ADDRESS. CITY, STATE, ZIP CODE B00 RIVER ROAD NEW MILFORD, NJ 07646 EDICATO DEFICIENCIES INST BE PRECEDED BY FULL DEFICIENCY CONSTRUCTION INST BE PRECEDED BY FULL DEFICIENCY F 610 F</td> <td>HUMAN SERVICES FOOM EDICAID SERVICES OMB NC DENTFICATION NUMBER: 315306 P. WING 315306 P. WING 315306 P. WING 315306 P. WING 315306 P. WING 315206 P. WING 315206 P. WING WING 315206 P. WING 315206 P. WING WING STREET ADDRESS, CITY, STATE, ZIP CODE 300 RVER ROAD NEW MILFORD, NJ 07546 PRETX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 610 F 61</td>	HUMAN SERVICES EDICAID SERVICES EDICAID SERVICES EDICAID SERVICES EDICAID SERVICES EDICAID SERVICES (2) MULTIPLE CONSTRUCTION A BUILDING 315306 B. WING STREET ADDRESS. CITY, STATE, ZIP CODE B00 RIVER ROAD NEW MILFORD, NJ 07646 EDICATO DEFICIENCIES INST BE PRECEDED BY FULL DEFICIENCY CONSTRUCTION INST BE PRECEDED BY FULL DEFICIENCY F 610 F	HUMAN SERVICES FOOM EDICAID SERVICES OMB NC DENTFICATION NUMBER: 315306 P. WING 315306 P. WING 315306 P. WING 315306 P. WING 315306 P. WING 315206 P. WING 315206 P. WING WING 315206 P. WING 315206 P. WING WING STREET ADDRESS, CITY, STATE, ZIP CODE 300 RVER ROAD NEW MILFORD, NJ 07546 PRETX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 610 F 61

Facility ID: NJ60222

If continuation sheet Page 8 of 9

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/30/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		315306	B. WING			_		C <b>26/2024</b>
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CAREON	E AT NEW MILFORD				800 RIVER ROAD NEW MILFORD, NJ 076	46		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610	Exorder 264(b)(1) night shift and the incident being rep- not interviewed by the were done on depend same assignment are Review of an "IDT me EMR under the "Prog Exorder 264(b)(1), indicated the EMR under the "Prog Exorder 264(b)(1), indicated the EMR under the "Prog Exorder 264(b)(1), indicated the EXORER 264(b)(1), indicated the Exorder 264(b)(1), indicated t	anal staff worked with R4 on and the next morning prior to ported. The five staff were e facility. No body checks dent residents living in the ea as the R4. eeting" note found in the ress Notes" tab dated lat the residen <sup>[EX.Order 26.4(b)(1)</sup> ere was no mention of how s policy titled, "Abuse, or Misappropriation - gating Policy," dated 09/22, t, "All reports of abuse inknown origin), neglect, nisappropriation of resident to local, state and federal d by current regulations) and ed by facility management gations are documented and egations are thoroughly	F	610				

Facility ID: NJ60222

If continuation sheet Page 9 of 9

	OF DEFICIENCIES	Ith (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (>	(3) DATE SURVEY COMPLETED
			B. WING		С
		060222			01/26/2024
AME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA ER ROAD	ATE, ZIP CODE	
AREONE	AT NEW MILFORD		LFORD, NJ 0764	16	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
S 000	Initial Comments		S 000		
	Complaint #: NJ0016 NJ00165673, NJ0016 NJ00154769, NJ0013 NJ00160103, NJ0016 NJ00165678 Survey Dates: 01/24/ Survey Census: 167	69205, NJ00152877, 56006, NJ00158089, 60808, NJ00161165, and			
	Code, Chapter 8:39, Long Term Care Faci submit a plan of corre completion date, for e that the plan is imple deficiencies may rest accordance with the	v Jersey Administrative Standards for Licensure of lities. The facility must ection, including a each deficiency and ensure mented. Failure to correct ult in enforcement action in Provisions of the New Jersey Title 8, Chapter 43E,			
S 560	8:39-5.1(a) Mandator (a) The facility shall of Federal, State, and lo regulations.	comply with applicable	S 560		2/2/24
	by: Complaint #: NJ0016 NJ00165673, NJ001 NJ00154769, NJ001	69205, NJ00152877, 56006, NJ00158089, 60808, NJ00161165, and		S560: 1. How the corrective action will be accomplished for those residents found have been affected by the deficient practice.	to
	-	-		,	1
RATORY [	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE

6899

If continuation sheet 1 of 6

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
					с
		060222	B. WING		01/26/2024
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE	
CAREONE	E AT NEW MILFORD		ER ROAD LFORD, NJ 076	46	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
S 560	Continued From pag	le 1	S 560		
	documentation. it wa	as determined that the facility		For periods of cited staffing reports -	no
		ing ratios were met to		residents were negatively affected ba	
		d minimum staff-to-resident		on CNA staffing deficiency.	
		by the state of New Jersey for			
	_	nd 13 of 35 overnight shifts			
		cient practice had the			
	potential to affect all	residents. Findings include:		2. How the facility will identify other	
	Boforonae: Now Jor	reav Department of Health		residents having the potential to be	
		rsey Department of Health ted 01/28/2021, "Compliance		affected by the same deficient practic For those residents identified during	
		lersey Statutes Annotated)		CNA staffing deficiency report dates	
		num staffing requirements for		were negatively affected by this defic	
		cated the New Jersey		practice.	
		o law P.L. 2020 c 112,			
	codified as N.J.S.A.	30:13-18 (the Act), which			
		n staffing requirements in			
	-	following ratio (s) were		3. What measures will be put into pl	
	effective on 02/01/20	)21:		or systemic changes made to ensure	that
	One Cartified Nurse	Aida (CNA) ta avary aight		the deficient practice will not recur.	
		Aide (CNA) to every eight shift. One direct care staff		Street facing signage advertising vacancies for RN's LPN's & CNA's w	ill be
		residents for the evening		posted prominently on facility's premi	
	•	o fewer of all staff members		Increased Salary rates for RN's LPN'	
		each direct staff member shall		CNA's	
	be signed into work a	as a certified nurse aide and		Sign-on Bonuses will be offered for F	RN's
	shall perform nurse a	aide duties: and one direct		LPN's & CNA's	
		every 14 residents for the		Recruitment incentive program for all	
		that each direct care staff		current employees who refer RN's LF	PN's
		to work as a CNA and		& CNA's	
	perform CNA duties.			Facility will sponsor CNA school for suitable CNA candidates and hire as	
	As nor the "Nurse St	affing Report" completed by		hospitality aides during CNA course	
		veeks of staffing from		Administrator or designee will screen	
	03/05/2023 to 03/11/	8		appropriate applicants and schedule	
		023 to 11/18/2023, and 2		interview with the Director of Nursing	
		m 01/07/2024 to 01/20/2024,		designee.	
	the staffing to reside	nt ratios did not meet the		Licensed Practical Nurses will work a	
		nt of one CNA to eight		C.N.A. to meet the C.N.A staffing rati	os
		shift and one direct care		when staffing permits.	.
	staff member to ever	ry 10 residents for the		The Administrator or designee will re-	view

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		060222	B. WING		01/26/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	ATE, ZIP CODE	
CAREONE	AT NEW MILFORD		ER ROAD ILFORD, NJ 0764	46	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE
S 560	Continued From page	e 2	S 560		
3 360	evening shift as doc 1. For the week of Co 03/05/2023 to 03/11/ deficient in CNA staff day shifts as follows: -03/05/23 had 17 CN day shift, required at -03/06/23 had 18 CN day shift, required at -03/07/23 had 18 CN day shift, required at -03/09/23 had 17 CN day shift, required at -03/09/23 had 19 CN day shift, required at -06/25/2023 to 07/01/ deficient in CNA staff day shifts and deficient on 6 of 7 overnight shift -06/25/23 had 11 CN day shift, required at -06/26/23 had 11 totat the overnight shift, re- -06/26/23 had 10 totat the overnight shift, re- -06/27/23 had 14 CN	umented below: omplaint staffing from 2023, the facility was fing for residents on 5 of 7 As for 170 residents on the least 21 CNAs. As for 169 residents on the least 21 CNAs. As for 169 residents on the least 21 CNAs. As for 167 residents on the least 21 CNAs. As for 167 residents on the least 21 CNAs. As for 167 residents on the least 21 CNAs. Complaint staffing from 2023, the facility was fing for residents on 7 of 7 ent in total staff for residents hifts as follows: As for 176 residents on the least 22 CNAs. al staff for 176 residents on equired at least 13 total staff. As for 176 residents on equired at least 13 total staff. As for 176 residents on equired at least 13 total staff. As for 176 residents on the least 22 CNAs.	5 300	<ul> <li>daily census with the Director of Nursor designee to ensure patient needs be met based on staffing. The Director of Nursing or designee review and monitor the staffing daily staffing coordinator to ensure the fact meeting mandatory staffing standard weeks and weekly for 3 months there Results of audits will be forwarded to administrator for review by facility QuAssurance Committee.</li> <li>4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected a will not recur, i.e. what program will be into place to monitor the continued effectiveness of the systemic change. The facility quality assurance commit will review the above mentioned aud and monitor for any trends and upda interventions as needed quarterly for quarters.</li> </ul>	can will with ility is ls 3 eafter. Juality and be put es. ttee its te
	day shift, required at -06/27/23 had 10 tota the overnight shift, re -06/28/23 had 19 CN day shift, required at	least 22 CNAs. al staff for 176 residents on equired at least 13 total staff. IAs for 176 residents on the least 22 CNAs. IAs for 180 residents on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		Ith (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
	060222		B. WING	0,	C 01/26/2024		
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE			
	E AT NEW MILFORD						
			LFORD, NJ 07646				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
S 560	Continued From pag	e 3	S 560				
	-06/29/23 had 11 tota the overnight shift, re -06/30/23 had 17 CN day shift, required at -06/30/23 had 11 tota the overnight shift, re -07/01/23 had 14 CN day shift, required at -07/01/23 had 10 tota the overnight shift, re 3. For the week of C 11/12/2023 to 11/18// deficient in CNA staff day shifts and deficie on 7 of 7 overnight shift, re -11/12/23 had 16 CN day shift, required at -11/12/23 had 16 CN day shift, required at -11/13/23 had 16 CN day shift, required at -11/13/23 had 15 CN day shift, required at -11/14/23 had 15 CN day shift, required at -11/14/23 had 15 CN day shift, required at -11/14/23 had 17 CN day shift, required at -11/15/23 had 17 CN day shift, required at -11/16/23 had 17 CN day shift, required at	al staff for 180 residents on equired at least 13 total staff. As for 180 residents on the least 22 CNAs. al staff for 180 residents on equired at least 13 total staff. As for 180 residents on the least 22 CNAs. al staff for 180 residents on equired at least 13 total staff. Complaint staffing from 2023, the facility was fing for residents on 7 of 7 ent in total staff for residents hifts as follows: As for 168 residents on the least 21 CNAs. al staff for 168 residents on equired at least 12 total staff. As for 168 residents on the least 21 CNAs. al staff for 168 residents on equired at least 12 total staff. As for 168 residents on the least 21 CNAs. al staff for 168 residents on equired at least 12 total staff. As for 168 residents on the least 21 CNAs. al staff for 168 residents on equired at least 12 total staff. As for 168 residents on the least 21 CNAs. al staff for 168 residents on equired at least 12 total staff. As for 168 residents on the least 21 CNAs. al staff for 168 residents on equired at least 12 total staff. As for 168 residents on the least 21 CNAs. al staff for 168 residents on equired at least 12 total staff. As for 168 residents on the least 21 CNAs. al staff for 168 residents on equired at least 12 total staff. As for 168 residents on the least 21 CNAs. al staff for 168 residents on the least 21 CNAs.					
	the overnight shift, re -11/17/23 had 17 CN day shift, required at	equired at least 12 total staff. As for 169 residents on the					

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		С		
	060222		B. WING			01/26/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
CAREONE	E AT NEW MILFORD						
(X4) ID	SUMMARY ST		LFORD, NJ 07646	PROVIDER'S PLAN O		(X5)	
PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLET	
S 560	Continued From pag	e 4	S 560				
	the overnight shift, re -11/18/23 had 16 CN day shift, required at -11/18/23 had 11 tota the overnight shift, re 4. For the 2 weeks of 01/07/2024 to 01/20/ deficient in CNA staff day shifts and deficie on 5 of 14 overnight -01/07/24 had 14 CN day shift, required at -01/07/24 had 12 CN day shift, required at -01/08/24 had 12 CN day shift, required at -01/09/24 had 16 CN day shift, required at -01/10/24 had 16 CN day shift, required at -01/12/24 had 13 CN day shift, required at -01/12/24 had 9.5 tot the overnight shift, re -01/13/24 had 16 CN day shift, required at -01/13/24 had 10 tota the overnight shift, re	equired at least 12 total staff. As for 169 residents on the least 21 CNAs. al staff for 169 residents on equired at least 12 total staff. of Complaint staffing from 2024, the facility was fing for residents on 14 of 14 ent in total staff for residents shifts as follows: IAs for 166 residents on the least 21 CNAs. al staff for 166 residents on the least 21 CNAs. IAs for 166 residents on the least 21 CNAs.					
	the overnight shift, re	staff for 167 residents on equired at least 12 total staff.					
	day shift, required at	IAs for 167 residents on the least 21 CNAs. IAs for 167 residents on the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN (	Barel Sourceston Indextron NUMBER.		A. BUILDING:		СОМ	PLETED
060222		060222	B. WING	01	C I/ <b>26/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
CAREON	E AT NEW MILFORD					
	SUMMARY ST		ILFORD, NJ 07646	PROVIDER'S PLAN C		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
S 560	Continued From pag	e 5	S 560			
	day shift, required at -01/18/24 had 16 CN day shift, required at -01/19/24 had 16 CN day shift, required at -01/19/24 had 11 tota the overnight shift, re	IAs for 166 residents on the least 20 CNAs. IAs for 166 residents on the least 20 CNAs. IAs for 166 residents on the least 20 CNAs. al staff for 166 residents on equired at least 12 total staff. IAs for 166 residents on the				

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
315306 <sub>Y1</sub>	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 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 DATE		ITEM DATE		ITEM		DATE		
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0609 483.12(b)(5)(i)(A) (1)(4)	Correction (B)(c) Completed 02/02/2024	ID Prefix Reg. # LSC	F0610 483.12(c)(2)-(4)	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
REVIEWE STATE AC REVIEWE CMS RO FOLLOWI 1/26/202		REVIEWED BY (INITIALS) REVIEWED BY (INITIALS) OMPLETED ON		SIGNATURE OF TITLE CK FOR ANY UNCORREC DRRECTED DEFICIENCI	CTED DEFICIENCIES		DATE DATE	3 🔲 NO

## STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT		
	A. Building B. Wing	Y2	2/20/2024	Y3	
	-	12	<u> </u>	13	
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).

ITEI	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix	S0560	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	8:39-5.1(a)	Completed	Reg. #		Completed	Reg. #		Completed
LSC		02/02/2024	LSC _		-			-
ID Prefix		Correction	ID Prefix _		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC _			LSC _		-
ID Prefix		Correction	ID Prefix _		Correction	ID Prefix _		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC _			LSC _		-
ID Prefix Reg. #		Correction Completed	ID Prefix – Reg. #		Correction	ID Prefix — Reg. #		Correction Completed
LSC			LSC –		-	LSC –		_
ID Prefix Reg. #		Correction Completed	ID Prefix – Reg. #		Correction	ID Prefix Reg. #		Correction Completed
LSC			LSC		oompicted	LSC		-
REVIEWE STATE AG REVIEWE		REVIEWED BY (INITIALS) REVIEWED BY	DATE	SIGNATURE OF SU	JRVEYOR		DATE	
CMS RO		(INITIALS)						
FOLLOWUP TO SURVEY COMPLETED ON 1/26/2024			FOR ANY UNCORRECTER				s 🗆 no	