STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. BUILDING _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	**544 TEANECK ROAD TEANECK, NJ 07666**

(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 #s NJ 155949, 158851, 162976, 163790, 164500, 166683, 168298, 170251, 170584, 171165 STANDARD SURVEY: 2/29/24 CENSUS: 87 SAMPLE SIZE: 21 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long-Term Care Facilities. Complaint investigations were also completed during this survey. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on the interview and record review, it was determined that the facility failed to code the Minimum Data Set (MDS), an assessment tool used to facilitate the management of care of all residents, accurately for 1 of 21 residents reviewed (Resident # 89).	F 641	Resident number 89 MDS titled Discharge Return anticipated Section A2105 was immediately modified to reflect resident being discharged to [redacted] on [redacted]. The MDS was submitted and accepted by CMS on	5/1/24

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

Electronically Signed | 03/21/2024

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F 641	Continued From page 1 The deficient practice was evidenced by the following: The surveyor reviewed Resident # 89's records. The resident was discharged from the facility and according to the Discharge Return Anticipated MDS, an assessment tool used to facilitate the management of care, dated NJ Ex Order 26.4b1, the resident was assessed as being discharged to NJ Ex Order 26.4b1. A review of Resident # 89's progress notes dated NJ Ex Order 26.4b1 revealed that the resident had a transfer to NJ Ex Order 26.4b as the resident had an increase in NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 which started on NJ Ex Order 26.4b1 and the symptoms had gotten worse. On 2/21/24 at 10:15 AM, the surveyor interviewed the U.S. FOIA (b) (6), who stated that the MDS under section A for Resident # 89 should have indicated discharge to NJ Ex Order 26.4b1 and that it was an error that it indicated discharge to NJ Ex Order 26.4b [redacted] During an interview on 2/28/24 at 1:00 PM, the surveyor brought the above concerns to the attention of the U.S. FOIA (b) (6) and U.S. FOIA (b) (6) A review of the policy regarding accuracy of resident assessment, reviewed 1/2/24, revealed "Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment."	F 641	2/28/24. All residents in the facility have the potential to be affected by the deficient practice. Education was provided to the entire MDS department on accurately coding the MDS, reviewing the MDS after completion and checking for accuracy of the MDS prior to signing and submitting. A facility wide audit was completed on all residents who discharged within the last month to ensure accurate coding of the MDS Education was provided to the entire MDS department on accurately coding the MDS, reviewing the MDS after completion and checking for accuracy of the MDS prior to signing and submitting. A facility wide audit was completed on all residents who discharged within the last month to ensure accurate coding of the MDS in section A. Audits will be monitored for completion by the DON/designee weekly for 4 weeks, every two weeks for 2 months and monthly x 2 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to	

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F 641	Continued From page 2 NJAC 8:39-11.2(e)1	F 641	QAPI Committee at least quarterly.	
F 658 SS=E	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: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice for not following physician orders for 3 of 21 residents reviewed (Resident # 19, #197, and #72) and b.) failed to document for accountability of medications and treatments administered for 3 of 21 residents reviewed (Resident #72, #196, and #197). The deficient practice 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 licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; 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. The surveyor reviewed the medical records for	F 658	F □ 658 SS = E Resident number 19 order for the NJ Ex Order 26.4b1 was immediately updated to reflect the column for the Supplemental documentation of the [redacted] to be entered. The U.S. FOIA (b) (6) was also notified of the [redacted] not being added to the order and not having proof of [redacted] being taken prior to administration of the medication before [redacted]. Resident number 72 U.S. FOIA (b) (6) was notified of the 8 times in [redacted] and [redacted] the [redacted] was given outside of the holding parameters. The [redacted] was also notified of the treatments not being administered for [redacted] including the [redacted], the NJ Ex Order 26.4b1, and the [redacted]. The [redacted] was also notified of the dates in [redacted] when the nurse did document the [redacted] NJ Ex Order 26.4b1 and the [redacted]	5/1/24

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F 658	Continued From page 3 Resident #19 and revealed the following: According to the NJ Ex Order 26.4b1 Order Summary Report (OSR) for Resident #19 had an order dated NJ Ex Order 2 for NJ Ex Order 26.4b1 Oral Tablet NJ Ex Order 2 Give 1 tablet by mouth two times a day for NJ Ex Order 26.4b1 Hold for NJ Ex Order 26.4b1 > or equal to NJ Ex O. The NJ Ex Order 26.4b1 electronic Medication Administration Records (eMAR) revealed that the order was written without a specified column to check the NJ Ex Ord and there was no proof that NJ Exec O was taken at the time that NJ Exec Order 26.4b1 was administered. On 2/28/24 at 10:39 AM, the surveyor interviewed the Licensed Practical Nurse (LPN #1), who stated the resident's NJ Ex was supposed to be checked prior to administration of NJ Ex Order 26.4b1 but after reviewing the eMAR, the LPN stated that nothing had come up which requested the resident's NJ Ex was to be taken and she was not able to prove if NJ Ex had ever been taken time of administration of the NJ Ex Order 26.4b1 for Resident #19. 2. The surveyor reviewed the medical records for Resident #72 and revealed the following: According to the NJ Ex Order 26.4b1 OSR sheet, Resident #72 had an order dated NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 two times a day with parameters to hold the medication when the NJ Ex Ord is more than NJ Ex Ord The NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 eMAR revealed several dates the nurse gave the	F 658	NJ Ex Order 26.4b1 For 2/3 the physician was notified of the NJ Ex Order 26.4b1 NJ Ex Order 26.4b1 NJ Ex Ord score, side effect tracking for the NJ Ex Order 26.4b1 and the NJ Ex Order 26.4b1 and the NJ Ex Orde not being documented. Resident number 196 and 197 were no longer at the center, however an audit was completed on residents Mars/Tars for missing signatures. And an audit was run on NJ Ex Order 26.4b1 to identify NJ Ex Order 26.4b1 being administered outside of holding parameters or being administered outside of the ordered times and pharmacy recommendations. All residents in the facility have the potential to be affected by the deficient practice. The Director of Nursing/designee conducted re-education to RNs and LPNs on documenting all medication and treatments administered to each resident in the medication administration record immediately after the medication or treatment is administered. The documentation of medication/treatment includes a minimum of the reason a medication/treatment was withheld, not administered, or refused. The Director of Nursing (and designee) conducted Audits of all residents mars and tars for NJ Ex Order 26.4b1. The Director of Nursing (and designee) conducted audits of all residents with NJ Ex Order 26.4b1 orders, to ensure parameters and vital sign documentation is present. Audits will be monitored for completion by the DON/designee weekly for 4 weeks, every two weeks for 2	

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F 658	Continued From page 4 NJ Ex Order 26.4b1 medication when the resident's NJ Ex Order 26.4b1 was above NJ Ex O. NJ Ex Order 26.4b1 was given when the NJ Ex Ord was above NJ Ex O by the 3-11 nurse on NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 26.4, and NJ Ex Order 26.4 and by the 7-3 nurse on NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 2, and NJ Ex Order 26.4. The surveyor interviewed LPN#2 on 2/22/24 at 10:48 AM. LPN#2 stated that the medication should not be given if it is outside of the ordered parameters. According to the January 2024 OSR, Resident #72 had physician orders for NJ Ex Order 26.4b1 to the NJ Ex O, NJ Ex Order 26.4b1 to the NJ Ex Order 26.4, NJ Ex Order 26.4b1, and NJ Ex Order 26.4b1. The NJ Ex Order 26.4b1 electronic Treatment Administration Record (eTAR) revealed that the evening shift nurse did not document the treatment on NJ Ex Order 26.4 of the following: 1. NJ Ex Order 26.4b1 are to be applied NJ Ex Order 26.4b to the NJ Ex Order 26.4b1 every day and evening shift for NJ Ex Order 26.4b1 2. Apply NJ Ex Order 26.4b1 every shift for protection to the NJ Ex Order 26.4b1. 3. Apply NJ Ex Order 26.4b1 every shift for protection to the NJ Ex Order 26.4b1. 4. Apply NJ Ex Order 26.4b1 every shift for protection to the NJ Ex Order 26.4b1. 5. NJ Ex Order 26.4b1 every shift for NJ Ex Or According to NJ Ex Order 26.4b1 OSR, Resident #72 had physician orders for NJ Ex Order 26.4b1 capsule by mouth in the evening, NJ Ex Order 26.4b1 by	F 658	months and monthly x 2 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly. All residents in the facility have the potential to be affected by the deficient practice The Director of Nursing/designee conducted re-education to RNs and LPNs on documenting all medication and treatments administered to each resident in the medication administration record immediately after the medication or treatment is administered. The documentation of medication/treatment includes a minimum of the reason a medication/treatment was withheld, not administered, or refused. The Director of Nursing (and designee) conducted Audits of all residents□ mars and tars for February 2024. The Director of Nursing (and designee) conducted audits of all residents with NJ Ex Order 26.4b1 orders, to ensure parameters and vital sign documentation is present. Audits will be monitored for completion by the DON/designee weekly for 4 weeks,	

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F 658	Continued From page 5 mouth in the evening, NJ Ex Or score every shift, NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 tracking every shift, and NJ Ex Order 26.4b1 one time a day for apply to the NJ Ex Order 26.4b1, NJ Ex Order 26.4b1 are to be applied NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 every day shift for NJ Ex Order 26 care, apply NJ Ex Order 26.4b1 every shift for NJ Ex Order 26.4b1 , NJ Ex Order 26.4b1 , and NJ Ex Order 26.4b1 . The NJ Ex Order 26.4b1 eMAR revealed that on NJ Ex Order 26, the evening shift nurse did not document the following medications: 1. NJ Ex Order 26.4b1 capsule by mouth in the evening. 2. NJ Ex Order 26.4b1 capsule by mouth in the evening. 3. NJ Ex Order 26.4b1 every shift. 4. NJ Ex Order 26.4b1 tracking every shift. 5. NJ Ex Order 26.4b1 tracking every shift. 6. NJ Ex Order 26.4b1 one time a day for NJ Ex Order 26.4 apply to the NJ Ex Order 26.4b1 7. NJ Ex Order 26.4b1 one time a day for NJ Ex Order 26.4 apply to the NJ Ex Order 26.4b1 . The NJ Ex Order 26.4b1 eTAR revealed that on NJ Ex Order 2 , the day shift nurse did not document the following treatments: 1. NJ Ex Order 26.4b1 are to be applied NJ Ex Order 26.4b to the NJ Ex Order 26.4b1 every day shift for NJ Ex Order 26 care. 2. Apply NJ Ex Order 26.4b1 every shift for protection to the NJ Ex Order 26.4b1 . 3. Apply NJ Ex Order 26.4b1 every shift for protection to the NJ Ex Order 26.4b1 . 4. Apply NJ Ex Order 26.4b1 every shift for protection to the NJ Ex Order 26.4b1 . 5. NJ Ex Order 26.4b1 every shift for NJ Ex Or	F 658	every two weeks for 2 months and monthly x 2 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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F 658	Continued From page 6	F 658		

NJ Ex Order 26.4b

3. The surveyor reviewed the medical records for Resident #196 and revealed the following:

According to the NJ Ex Order 26.4b1 OSR, Resident #196 had physician orders for NJ Ex Order 26.4b1 tablet by mouth at bedtime, NJ Ex Order 26.4b1: NJ Ex Order 26.4b1 every shift, NJ Ex Order 26.4b1 score every shift, NJ Ex Order 26.4b1 tracking every shift, vital signs every shift NJ Ex Order 26.4b1 apply to NJ Ex Order 26.4b1 every day shift for NJ Ex Order 26 care, and NJ Ex Order 26.4b1 four times a day.

The NJ Ex Order 26.4b1 eMAR revealed that on NJ Ex Order 26.4b1, the evening shift nurse did not document the following:

1. NJ Ex Order 26.4b1 tablet by mouth at bedtime.
2. NJ Ex Order 26.4b1: NJ Ex Order 26.4b1 every shift.
3. NJ Ex Order 26.4b1 every shift.
4. NJ Ex Order 26.4b1 tracking every shift.
5. Vital signs every shift.

The December 2023 eTAR revealed that on NJ Ex Order 26.4b1 and NJ Ex Order 26.4b1 respectively, the day and evening shift nurse did not document the following:

1. NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 every day shift for NJ Ex Order 26 care.
2. NJ Ex Order 26.4b1 four times a day.

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F 658	Continued From page 7	F 658		

4. The surveyor reviewed the medical records for Resident #197 and revealed the following:

According to the NJ Ex Order 26.4b1 OSR sheet, Resident #197 had an order dated NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 every 8 (eight) hours with parameters to hold the medication when the NJ Ex Ord is more than NJ Ex O. Do not administer after the evening meal or 4 (four) hours from bedtime to avoid NJ Ex Order 26.4b1.

The NJ Ex Order 26.4b1 eMAR revealed that on NJ Ex Order 26.4b, NJ Ex Order 26.4, NJ Ex Order 26.4, and NJ Ex Order 26.4, the NJ Ex Order 26.4b1 was given without the NJ Ex Order 26.4b1 written in the order.

The NJ Ex Order 26.4b1 eMAR revealed that on NJ Ex Order 26.4b1 NJ Ex Order 26.4, NJ Ex Order 26.4b, and NJ Ex Order 26.4, the NJ Ex Order 26.4b1 was given at 2200 (10:00 PM) 4 hours from bedtime.

The NJ Ex Order 26.4b1 eMAR revealed that on NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 26.4, and NJ Ex Order 26.4, the NJ Ex Order 26.4b1 was given at 2200 after the evening meal or 4 hours from bedtime.

The NJ Ex Order 26.4b1 eMAR revealed that the NJ Ex Order 26.4b1 was not documented on NJ Ex Order 26.4b at 1400 (2:00 PM), NJ Ex Order 26.4 at 0600 (6:00 AM), and NJ Ex Order 26.4 at 1400 (2:00 PM) and 2200.

According to the NJ Ex Order 26.4b1 OSR sheet, Resident #197 had an order dated NJ Ex Order 26.4b1 for NJ Ex Order 26.4b1 every 8 (eight) hours with parameters to hold the medication when the NJ Ex Ord is more than NJ Ex O. Do not give after 8:00 PM.

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F 658	Continued From page 8	F 658		

The NJ Ex Order 26.4b1 eMAR revealed that on NJ Ex Order 26.4, NJ Ex Order 26.4, and NJ Ex Order 26.4, the NJ Ex Order 26.4b1 was given at 2200 after 8:00 PM.

The NJ Ex Order 26.4b1 eMAR revealed that the NJ Ex Order 26.4b1 was not documented on NJ Ex Order 26.4 at 1400.

According to the NJ Ex Order 26.4b1 OSR sheet, Resident #197 had a physician order of NJ Ex Order 26.4b1 by mouth two times a day, vital signs every shift, NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 every day NJ Ex Order 26.4b1 apply to NJ Ex Order 26.4b1 every shift, NJ Ex Order 26.4b1 4 times a day.

The NJ Ex Order 26.4b1 eMAR revealed that the NJ Ex Order 26.4b1 was not documented on NJ Ex Order 26.4b at 1800 (6:00 PM) and 2200.

The NJ Ex Order 26.4b1 eMAR revealed that on NJ Ex Order 26.4b and NJ Ex Order 26.4, the day shift nurse did not document the vital signs every shift.

The NJ Ex Order 26.4b1 eTAR revealed that there were several dates that the nurse did not document the treatments was done on the following dates:

1. NJ Ex Order 26.4b1 to the NJ Ex Order 26.4b1 every day on NJ Ex Order 26.4, NJ Ex Order 26.4b, and NJ Ex Order 26.4 on day shift.
2. NJ Ex Order 26.4b1 apply to the NJ Ex Order 26.4b1 every shift on NJ Ex Order 26.4 on the day shift.
3. NJ Ex Order 26.4b1 4 (four) times a day on NJ Ex Order 26.4 at 1800 and 2200, on NJ Ex Order 26.4 at 1000 (8:00 AM) and 1400, and on NJ Ex Order 26.4b at 1000 and 1400.

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F 658	Continued From page 9 On 2/28/24 at 12:56 PM, the surveyors discussed the above concerns with the U.S. FOIA (b) (6) U.S. FOIA (b) (6)), and U.S. FOIA (b) (6) . There was no information provided. A review of the facility's policy titled "Documentation of Medication Administration" with a revised date of November 2022 indicated under "Policy Interpretation and Implementation 1. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR). The medication administration record may be a paper record or an electronic equivalent. 2. Administration of medication is documented immediately after it is given. 3. Documentation of medication administration includes, as a minimum: f. reason(s) why a medication was withheld, not administered, or refused (as applicable); g. initials, signature, and title of the person administering the medication."	F 658		
F 842 SS=D	NJAC 8:39-27.1(a) Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.	F 842		5/1/24

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F 842	Continued From page 10	F 842		

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. BUILDING _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

(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 842	Continued From page 11 there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to follow professional standards and practices to accurately document in the medical record the status of a resident's progress or changes in his/her condition. The resident was transferred from the facility to the [redacted]. The concern was cited for 1 (Resident #199) of 21 residents reviewed and is evidenced by the following: Resident #199 is not in the facility and will investigate the closed record and conduct interviews. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are (ii) accurately documented. The medical record must contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of	F 842	Resident number 199 no longer resides in the facility; however, a review of the nursing documentation and the maintenance of medical records were reviewed with the nursing department and included the medical records designee/staff. The facility policy for charting and documentation and acute condition changes were reviewed by the nursing leadership team. All residents in the facility have the potential to be affected by the deficient practice. The Director of Nursing provided re-education to the entire nursing department (RNs and LPNs) on accurate and timely documentation when there is a	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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F 842	Continued From page 12 the resident's progress, including his/her response to treatments and/or services, and changes in his/her condition, plan of care goals, objectives and/or interventions. A review of the 5 Day [NJ Exec Order] Minimum Data Set (MDS), a facility assessment tool, revealed the resident's Brief Interview for Mental Status (BIMS) [NJ Ex] out of 15 indicating [NJ Ex Order 26.4b1]. The admission record indicated the resident was admitted to the facility with diagnoses that included but were not limited to [NJ Ex Order 26.4b1] [NJ Ex Order 26.4b1], [NJ Ex Order 26.4b1] [NJ Ex Order 26.4b1], [NJ Ex Order 26.4b1], [NJ Ex Order 26.4b1], [NJ Ex Order 26.4b1], [NJ Ex Order 26.4b1]. A review of the nursing progress notes revealed missing nursing documentations for [NJ Ex Order 26.4], [NJ Ex Order 26.4], [NJ Ex Order 2], [NJ Ex Order 2], and [NJ Ex Order 2], the day the resident was transferred to the hospital. On 2/20/23 at 1:50 PM, the surveyor discussed the concerns of lack of nursing documentation for Resident #199 on the day of change in condition [NJ Ex Order 2], with U.S. FOIA (b) (6)) in training, sitting U.S. FOIA (b) (6) , and the U.S. FOIA (b) (6)). The surveyor requested from the facility for any additional documentations, grievances, or investigations during the resident's stay. On 2/22/24 at 10:00AM, the [U.S. FOIA] and [U.S. FOIA (b)] provided documentation of the timeline on the day resident was transferred to the hospital. The timeline revealed that on [NJ Ex Order 2] the resident was transferred on [NJ Ex Order 2] at 7:30 AM via 911 ambulance for complaint of [NJ Ex Order 26.4b1]. The resident was admitted with [NJ Ex Order 26.4b1] and	F 842	change in resident□s condition. The Director of Nursing (and designee) conducted an audit for all residents who had a change in condition in the last 30 days, to ensure appropriate documentation in the EHR. The Director of Nursing (and designee) conducted an audit for all residents who were transferred out to the hospital in the last 30 days to ensure appropriate documentation in the EHR, was completed for the changes in the residents□ condition. Audits of residents who experience a change in condition, will be monitored for completion by the DON/designee weekly for 4 weeks, every two weeks for 2 months and monthly x 2 months. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee at least quarterly.	

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	315502	A. BUILDING _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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F 842	Continued From page 13	F 842		

NJ Ex Order 26.4b1 The timeline provided was not documented in the resident's EHR.

On 2/23/24 at 9:50 AM, interviewed the sitting U.S. FOIA U.S. FOIA regarding nursing documentation and the stated, "It is the expectation that nursing will document every shift in the EHR under the progress notes." The surveyor reviewed with the U.S. FOIA and the U.S. FOIA (b) the missing nursing documentations on NJ Ex Order 26.4, NJ Ex Order 26.4, NJ Ex Order 2, NJ Ex Order 2, and NJ Ex Order 2. The professional standards of practices §483.70(i)(1), mentioned above was also reviewed with the U.S. FOIA and the U.S. FOIA (b)

On 2/28/24 at 10:40 AM, interviewed the US FOIA on the NJ Ex floor, the US FOIA stated, "We do skilled nursing notes, we should document on residents that has something going on. I document on residents that go out, when the doctor was notified and of course the family and who I spoke to. I document on how the resident was transported, the reason that they're going out. I try to document on all the residents daily."

The surveyor reviewed the current facility policy and procedures titled Charting and Documentation revised 5/27/22 and Acute Condition Changes revised 3/2018, which revealed "The following information is to be documented in the resident medical record: Changes in the resident's condition."

NJAC 8:39-35.2(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02002	A. BUILDING: _____ B. WING _____	C 02/29/2024

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CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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S 000	Initial Comments Complaint #NJ 163790, 155949, 164500. The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Complaint # NJ 155949, 164500, 163790 Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18	S 560	The facility continues to follow a recruitment plan to attract Certified Nurse Assistant staff. Leadership has met and will continue to meet on an ongoing basis to identify staffing challenges and areas of improvement for licensed certified nursing needs. Staffing coordinator to meet with the DON 5 days a week to discuss opening Census and the state ratio requirements for Certified nursing assistance. All residents in the facility have the potential to be affected by this practice.	4/30/24

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

Electronically Signed | 03/21/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02002	A. BUILDING: _____ B. WING _____	C 02/29/2024

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S 560	Continued From page 1 Minimum staffing requirements for nursing homes effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift. (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties, and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than	S 560	The Director of Nursing conducted an audit of staffing schedules with the current facility census to ensure fulfillment of staffing requirements per shift. Ongoing efforts to recruit are in place and will be revised according to the center needs. The facility has implemented an incentive program including referral bonuses for employees referring staff where appropriate. Recruitment and referral of unlicensed individuals to the Company□s Certified Nursing Assistant training course in Bergen County. The facility will conduct Job fairs with immediate interviews and contingency offers with an expedited onboarding process of new hires. The DON/designee will meet with the staffing coordinator daily to review call outs and facility census vs staffing needs. The DON/designee will monitor ratios weekly until the requirement is met. Audits will be discussed during Quality Assurance Performance Improvement Committee meeting. QAPI committee will determine if continued auditing is necessary once 100% compliance threshold is met for two or more consecutive months. This plan can be amended when indicated. Adverse findings will be immediately addresdsed. Findings ad trends will be reported to QAPI committee at least quarterly.	

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S 560	Continued From page 2	S 560		

a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher.

(3) All computations shall be based on the midnight census for the day in which the shift begins.

d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ...

A review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Reports for 16 weeks of staffing for 4 distinct time periods received from facility administration during the 2/29/2024 Standard survey with Complaints revealed deficient staffing ratios as evidenced by the following:

For the week of Complaint staffing from 5/29/2022 to 6/4/2022, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows:

- 5/29/22 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs.
- 6/2/22 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs.

For 4 weeks of Complaint staffing from

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	02002	A. BUILDING: _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 560	Continued From page 3 04/09/2023 to 05/06/2023, the facility was deficient in CNA staffing for residents on 8 of 28 day shifts as follows: - 4/9/23 had 7 CNAs for 74 residents on the day shift, required at least 9 CNAs. - 4/14/23 had 9 CNAs for 79 residents on the day shift, required at least 10 CNAs. - 4/22/23 had 8 CNAs for 84 residents on the day shift, required at least 10 CNAs. - 4/23/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. - 4/28/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. - 5/1/23 had 9 CNAs for 88 residents on the day shift, required at least 11 CNAs. - 5/4/23 had 11 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 5/6/23 had 9 CNAs for 86 residents on the day shift, required at least 11 CNAs. For 9 weeks of Complaint staffing from 10/1/2023 to 12/2/2023, the facility was deficient in CNA staffing for residents on 31 of 63 day shifts as follows: - 10/7/23 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. - 10/8/23 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs. - 10/9/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs. - 10/10/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs. - 10/13/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 10/14/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 10/15/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs.	S 560		

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S 560	Continued From page 4 - 10/16/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. - 10/17/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. - 10/21/23 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. - 10/22/23 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. - 10/23/23 had 8 CNAs for 87 residents on the day shift, required at least 11 CNAs. - 10/26/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs. - 10/27/23 had 9 CNAs for 84 residents on the day shift, required at least 10 CNAs. - 10/29/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 10/30/23 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. - 10/31/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. - 11/1/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. - 11/2/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. - 11/3/23 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. - 11/5/23 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs. - 11/10/23 had 10 CNAs for 86 residents on the day shift, required at least 11 CNAs. - 11/12/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 11/15/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 11/18/23 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 11/19/23 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 11/20/23 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	02002	A. BUILDING: _____ B. WING _____	C 02/29/2024

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CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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S 560	Continued From page 5 - 11/22/23 had 10 CNAs for 90 residents on the day shift, required at least 11 CNAs. - 11/24/23 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. - 11/26/23 had 9 CNAs for 87 residents on the day shift, required at least 11 CNAs. - 11/28/23 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs. For 2 weeks of staffing prior to the Standard Survey from 1/28/2024 to 2/10/2024, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: - 1/28/24 had 10 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 1/29/24 had 8 CNAs for 93 residents on the day shift, required at least 12 CNAs. - 1/30/24 had 10 CNAs for 92 residents on the day shift, required at least 11 CNAs. - 2/2/24 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. - 2/3/24 had 9 CNAs for 92 residents on the day shift, required at least 11 CNAs. - 2/4/24 had 10 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 2/5/24 had 9 CNAs for 91 residents on the day shift, required at least 11 CNAs. - 2/6/24 had 10 CNAs for 89 residents on the day shift, required at least 11 CNAs. - 2/8/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. - 2/10/24 had 10 CNAs for 87 residents on the day shift, required at least 11 CNAs. The surveyor reviewed the facility policy and procedure for Staffing, Sufficient and Competent Nursing (revised August 2022) which was provided by the Director of Nursing (DON). Step 7 of the policy interpretation and implementation	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 560	Continued From page 6 indicated minimum staffing requirements imposed by the State are adhered to when determining staff ratios. On 2/29/24 at 1:15 p.m. the surveyor discussed with the DON and the Administrator the shifts which were below the minimum staffing ratios.	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)
315502	A. Building B. Wing	5/2/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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 F0641 Reg. # 483.20(g) LSC	Correction Completed 05/01/2024	ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 05/01/2024	ID Prefix F0842 Reg. # 483.20(f)(5), 483.70(i)(1)-(5) LSC	Correction Completed 05/01/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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	
2/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
02002 Y1	A. Building B. Wing Y2	5/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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 04/30/2024	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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 2/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	**544 TEANECK ROAD** **TEANECK, NJ 07666**

(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 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 02/28/2024 in the presence of facility management, it was determined that the facility failed to provide automatic fire sprinkler protection to all areas of the facility in accordance with NFPA 13 and NFPA 101:2012 Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 87 residents of the facility and was evidenced by the following: At 9:15 AM in the presence of the facility's U.S. FOIA (b) (6)) and U.S. FOIA (b) (6)), the surveyor observed that the roof overhang at the	K 351	2/28/24 the Environmental Director contacted NJ Ex Order 26.4b1 and NJ Ex Order 26.4b (vendors) for quotes for installation of an automatic fire sprinkler. No residents were adversely affected by this practice All residents residing in the facility have the potential to be affected by this practice. Sprinkler head will be installed in the delivery/receiving area as required. The Director of Maintenance (or	4/30/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	**544 TEANECK ROAD** **TEANECK, NJ 07666**

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K 351	Continued From page 1 delivery/receiving area was not provided with automatic fire sprinkler protection. The overhang measured 12-feet by 7-feet, was constructed with combustible materials and was attached to the building. In an interview at the time of observation, the [redacted] and [redacted] confirmed the findings. The facility's [redacted] was notified of the deficient practice during the Life Safety Code survey exit conference at 2:45 PM. NJAC 8:39-31.1(c), 31.2(e) NFPA 13	K 351	designee) will monitor the delivery area daily to ensure it remains free of combustible items until the sprinkler head is installed. The Director of Maintenance will report findings of these audits weekly to the Administrator, until sprinkler is installed.	
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 This REQUIREMENT is not met as evidenced	K 353		4/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	**544 TEANECK ROAD** **TEANECK, NJ 07666**

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K 353	Continued From page 2 by: Based on observation, interview, and documentation review on 02/27/2024, it was determined that the facility failed to inspect and test facility's private fire hydrant in accordance with NFPA 25 and NFPA 101:2012 Sections 9.7 and 19.3.5.1. This deficient practice had the potential to affect all 87 residents of the facility and was evidenced by the following: During documentation review, the facility failed to provide any record on inspection and testing for facility's private hydrant. At 12:00 PM, an interview was conducted with the U.S. FOIA (b) (6) and the U.S. FOIA (b) (6). The U.S. FOIA (b) stated that there were discrepancies between water vender and sprinkler service, so inspection and testing was not conducted. The U.S. FOIA (b) (6) was notified of the deficient practice at 2:45 PM during the Life Safety Code exit conference on 02/28/2024. NJAC 8:39-31.2 NFPA 25	K 353	The vendor, NJ Ex Order 26.4b was contacted by the Environmental Director on 2/27/24 to inspect the facility□s private fire hydrant. (see attached service inspection report). No residents were negatively affected by this practice. All residents residing in the facility have the potential to be affected by this practice. On 1/28/24 the vendor, NJ Ex Order 26.4b conducted a service visit to the facility to inspect the facility□s fire hydrant. The fire hydrant passed it□s yearly inspection. Fire hydrant will be inspected yearly. The Director of Maintenance (or designee) will ensure annual inspections are completed for the facility□s private fire hydrant. The Director of Maintenance will report findings to the Adminstrator and QAPI on an annual basis.	
K 524 SS=D	HVAC - Direct-Vent Gas Fireplaces CFR(s): NFPA 101 Direct-Vent Gas Fireplaces Direct-vent gas fireplaces, as defined in NFPA 54, inside of all smoke compartments containing patient sleeping areas comply with the requirements of 18.5.2.3(2), 19.5.2.3(2). 18.5.2.3(2), 19.5.2.3(2), NFPA 54	K 524		4/30/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	**544 TEANECK ROAD** **TEANECK, NJ 07666**

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K 524	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations and interview on 02/28/2024 in the presence of facility management, it was determined that the facility failed to provide (1) a protective wire mesh or screen on a Direct-Vent Gas Fireplace and (2) electrically supervised carbon monoxide detection in accordance with NFPA 54 and NFPA 101:2012 Sections 9.8, 19.5.2.3. (2)d 19.5.2.3. (2)f. This deficient practice had the potential to affect all 87 residents of the facility and was evidenced by the following: At 11:28 AM, the surveyor observed a Direct-Vent Gas fireplace with no protective wire mesh or screen located in the 1st floor main dining room. At approximately 11:30 AM the surveyor observed that the Direct-Vent gas fireplace was provided with a battery operated carbon monoxide detector, not the required hard wired carbon monoxide detector interconnected to the fire alarm system. In an interview at the time of observations, the U.S. FOIA (b) (6) confirmed the findings. The facility's U.S. FOIA (b) (6) was notified of the deficient practice during the Life Safety Code survey exit conference at 2:45 PM. NJAC 8:39-31.2 (e) NFPA 54	K 524	The fireplace in the main dining area was immediately taken out of service. No residents were adversely affected. All residents have the potential to be affected by this practice. The fireplace was immediately taken out of service. The following vendors: NJ Ex Order 26.4b1, NJ Ex Order 26.4b and NJ Ex Order 26.4b1 were all contacted by the Environmental Director on 2/29/24 for quotes for installation of a custom screen /protective mesh for the Direct-Vent fireplace, as well as for the placement of a hard-wired carbon monoxide detector. The Director of Maintenance (or designee) will monitor the fireplace daily to ensure it remains out of service until the custom screen and carbon monoxide detector are installed. Findings will be reported quarterly to the Administrator and present at QAPI Meetings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

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K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced	K 923		4/30/24

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	315502	A. BUILDING **01** B. WING _____	**02/29/2024**

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K 923	Continued From page 5 by: Based on observation on 02/28/2024 in the presence of the facility U.S. FOIA (b) (6) and U.S. FOIA (b) (6)), it was determined that the facility failed to transport a cylinder of compressed oxygen in a manner that would protect it against tipping, and rupture in accordance with NFPA 99 and NFPA 101:2012 Sections 8.7. This deficient practice was identified for 1 of 1 compressed portable cylinder observed and was evidenced by the following: At 10:06 AM on the first-floor hallway near the laundry, the surveyor observed a US FOIA (b)(6) transporting a portable compressed oxygen cylinder. The cylinder was not contained in a caddy or secured in a way from tipping, rupture, and damage. An interview was conducted with the U.S. FO during the time of observation, and he stated that "portable oxygen bottles should not be transported in that manner". The facility's U.S. FOIA (b) (6) was notified of the deficient practice at the Life Safety Code survey exit conference at 2:45 PM. NJAC 8:39-31.2 (e) NFPA 99	K 923	The US FOIA (b)(6) was immediately educated by the Director of Nursing on the proper way to transport oxygen cylinders within the facility. No residents were adversely affected by this practice All residents residing in the facility have the potential to be affected by this practice. The Director of Nursing (and designee) provided Inservice education provided to all staff for proper handling of Oxygen containers while transporting. The Director of Maintenance (or designee) will monitor staff transporting oxygen cylinders daily x 7 days, weekly x 4 weeks, monthly x 3 months. With results to the Administrator and QAPI x 3 months.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315502 Y1	A. Building 01 - CARE ONE AT TEANECK B. Wing Y2	5/2/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT TEANECK	544 TEANECK ROAD TEANECK, NJ 07666

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0351	04/30/2024	LSC K0353	04/30/2024	LSC K0524	04/30/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0923	04/30/2024	LSC		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
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ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
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LSC		LSC		LSC	

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	
2/29/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO