STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315511	A. BUILDING _____ B. WING _____	C 01/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	**101 WHIPPANY ROAD WHIPPANY, NJ 07981**

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F 000	INITIAL COMMENTS	F 000		

A Recertification and Complaint Survey was conducted by Healthcare Management Solutions on behalf of the New Jersey Department of Health.

Complaint #: NJ152404, NJ153519, NJ153897, NJ154244, NJ154252, NJ155977, NJ157896, NJ158712

On 01/24/24 at 8:01 PM, the Administrator and Director of Nursing were notified that an Immediate Jeopardy existed at F880-J Infection Control due to the failure to sanitize multi-use glucometer between residents per manufacturer's instructions.

The facility provided an acceptable Removal Plan of the Immediate Jeopardy which the survey team verified implementation and removed the Immediate Jeopardy on 01/25/24 at 6:36 PM. The deficient practice remained at a scope and severity of D (isolated for no actual harm with the potential for more than minimal harm that is not immediate jeopardy) following the removal of the Immediate Jeopardy.

Survey Dates: 01/22/24 to 01/25/24

Survey Census: 75
Sample Size: 28
Supplemental Residents: 3

THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS RECERTIFICATION AND COMPLAINT VISIT.

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

Electronically Signed | 02/12/2024

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F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review, the facility failed to update one resident's (R)47) status by completing a significant change Minimum Data Set (MDS) assessment when R47 was admitted to [NJ Exec. Order 26:4.b.1] on [NJ Exec. Order 26:2]. This failure affected one of five residents reviewed for MDS assessment concerns, in a sample of 28 residents. Findings include: Review of R47's "Face sheet" found in the "Profile" tab of the Electronic Medical Record (EMR) revealed R47 was admitted to the facility on [NJ ex order 26.4b1] with diagnosis of [NJ ex order 26.4b1] Review of R47's quarterly "MDS" with an assessment reference date (ARD) of [NJ ex order 26.4] documented that R47 had a Brief Interview for Mental Status score of [NJ ex] out of 15, which indicated [NJ ex order 26.4b1].	F 637	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #47 [NJ ex order 26.4b1] was immediately changed in the MDS to reflect his [NJ ex order 26.4b1] status. How the facility will identify other residents having the potential to be affected by the	2/12/24

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F 637	Continued From page 2 Review of R47's EMR "physician's order" dated [NJ ex order 26.4b1] revealed admit R47 to [NJ ex order 26.4b1]. Review of the [NJ ex order 26.4b1] dated [NJ ex order 26.4b1] found in the "MISC" tab in the EMR revealed that on [NJ ex order 26.4b1] NJ ex order 26.4b1 Review of the EMR revealed that there was no updated "MDS" assessment to address R47's NJ ex order 26.4b1 . Review of the facility policy titled "Change in Resident Condition or Status," revised February 2021 revealed, " ...2. A "significant change" of condition is a major decline or improvement in the resident's status that: a. will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions. b. impacts more than one area of the resident's health status. c. requires interdisciplinary review and/or revision to the care plan; and d. ultimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument (RAI). Interview with the MDS Coordinator on 01/25/24 at 3:50 PM revealed the facility policy was not followed because admission [NJ Exec. Order 26:4.b.] services would be a condition/status that would warrant a Significant Change MDS assessment. She further confirmed there had not been a timely Significant Change MDS completed for R47 when his status changed [NJ Exec. Order 26:4.b.1] ago." NJAC 8:39-11.2(i)	F 637	same deficient practice. - All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/25/2024, the Administrator and DON met with the MDS coordinator and reviewed the facility policy and processes on updating residents' MDS assessments when a significant change is identified. The MDS coordinator completed an audit on all hospice residents in the facility and no missed MDS assessments were identified. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The Regional Clinical Reimbursement Coordinator or designee will perform five (5) chart audits on residents with identified significant	

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F 637	Continued From page 3	F 637	changes monthly X 3 months and then quarterly X 3 quarters. The Regional Clinical Reimbursement Coordinator or designee will present the results of the audit to the Quality Assurance Committee for review and determine the need for further performance improvement. The Regional Clinical Reimbursement Coordinator or designee will perform five (5) chart audit on residents with identified significant change monthly X 3months, and then quarterly X 3 quarters	
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 observation, record review, interviews, review of facility policy, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure three residents (Resident (R)4, R14, and R17) out of 28 sampled residents had an accurate Minimum Data Set (MDS) assessment. Findings include: 1. Observation on 01/24/24 at 4:00PM revealed R4 had a NJ Exec. Order 26:4.b.1 draining NJ Exec. Order 26:4.b.1 in the right flank area.	F 641	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #4 NJ ex order 26.4b1 was updated/listed in the MDS Section NJ ex [redacted] - Resident #14 NJ ex order 26.4b1 [redacted] - Resident #17 NJ ex order 26.4b1 [redacted] which were present on	2/8/24

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F 641	Continued From page 4 Review of R4's "Admission Record" located in the electronic medical record (EMR) tab "Profile" revealed the resident was admitted to the facility with diagnoses that included NJ ex order 26.4b1 [redacted]. Review of R4's "Physician's Orders" dated NJ ex order 26.4b1 located in the EMR tab "Orders" revealed NJ ex order 26.4b1 [redacted]. Review of R4's quarterly "MDS" with an Assessment Reference Date (ARD) NJ ex order 26.4b1 located in the resident's EMR tab "MDS" revealed the NJ ex order 26.4b1 was not listed in the MDS section for NJ ex order 26.4b1 [redacted]. 2. Review of R14's "Admission Record" located in the EMR tab "Profile" revealed the resident was NJ ex order 26.4b1 [redacted]. Review of R14's "Physician Orders" dated NJ ex order 26.4b1 located in the EMR tab "Orders" revealed the resident was to receive NJ ex order 26.4b1 NJ ex order 26.4b1 [redacted]. Review of the R14's "Quarterly MDS" with an ARD NJ ex order 26.4b1 located in the resident's EMR tab "MDS" revealed it was documented the resident received an NJ ex order 26.4b1 [redacted]. However, in section N0450 it was documented that the resident was NJ ex order 26.4b1 [redacted].	F 641	admission were updated in the MDS to reflect the current care and treatment resident receives. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by this practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/25/2024, the Administrator and DON met with the MDS coordinator and provided education on the importance of capturing and transmitting accurate MDS to reflect residents' diagnosis, medications and/or treatment as well as care and services received. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The MDS Coordinator or designee will perform five (5) MDS assessment audits 2X monthly, then monthly X 2 month to ensure full compliance. - The Regional Clinical Reimbursement Coordinator or designee will review and present the results of the audit to the Quality Assurance Committee for review and	

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F 641	Continued From page 5 3. Review of R17's "Admission Record" located in the EMR tab "Profile" revealed the resident was NJ ex order 26.4b1 [redacted] Review of R17's NJ ex order 26.4b1 " dated NJ ex order 26.4b1 located in the EMR tab "Miscellaneous" revealed the resident NJ ex order 26.4b1 [redacted] Review of R17's quarterly "MDS" with an ARD of NJ ex order 26.4b1 revealed the resident was assessed to have NJ ex order 26.4b1 [redacted] Interview on 01/25/24 at 2:30PM, the Minimum Data Set (MDS) Coordinator in the presence of the Director of Nursing revealed the MDS should reflect the resident's condition and the care the resident receives. The above residents were reviewed by the MDS Coordinator, and she agreed the MDS for these residents were inaccurate. Review of the facility's policy titled "Quarterly MDS Assessment" dated October 2023 revealed, "Quarterly MDS assessments are conducted to track the resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored ..." Review of the RAI Manual," dated 10/01/19,	F 641	determine the need for further performance improvement The MDS Coordinator or designee will perform five (5) MDS assessments audits 2X monthly, then monthly X 2 months to ensure full compliance	

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F 641	Continued From page 6 indicated, ". . . information obtained should cover the same observation period as specified by the Minimum Data Set (MDS) items on the assessment and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [Interdisciplinary Team] completing the assessment. . ."	F 641		
F 657 SS=D	NJAC 8:39-11.2(h) Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		2/8/24

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F 657	Continued From page 7 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revised/update care plans for two Residents (R)39 and R74 from a sample of 28 residents. The facility failed revised R39's care plan to reflect a NJ ex order 26.4b1 and R74's care plan regarding NJ ex order 26.4b1. Findings include: 1. Review of R39's "Admission Record" located in the electronic medical record (EMR) "Profile" tab revealed the resident was admitted to the facility on NJ ex order 26.4b1 with diagnoses that included NJ ex order 26.4 [redacted] Review of R39's "Nursing Notes" dated NJ ex order 26.4b1 located in the EMR "Progress notes" tab revealed the resident was NJ ex order 26.4b1 [redacted] Review of R39's "Care Plan" with a revision date of NJ ex order 26.4b1 located in the EMR "Care Plan" tab did not reflect the resident's NJ ex order 26.4b1 [redacted] Interview on 01/25/24 at 2:30PM, the Minimum Data Set (MDS) Coordinator confirmed that the resident's care plan was not revised to reflect the NJ ex order 26.4b1 [redacted] 2. Review of R74's "Face sheet" found in the "Profile" tab of the EMR revealed R74 was	F 657	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #39 care plan was immediately updated to reflect the NJ ex order 26.4b1 [redacted]. - Resident #74 care plan was immediately updated to reflect NJ ex order 26.4b1 [redacted] 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by this practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/26/2024, the DON conducted an audit on the comprehensive care plan of residents with falls, as well as residents requiring oxygen in the last thirty (30) days to ensure method of delivery is documented in the care plan. - On 1/26/2023, the DON and ADON provided education to the nursing staff on the facility's comprehensive, person-centered care plan policy. - Nursing staff were also educated on the importance of reporting residents' significant change in condition, such as falls, to their supervisor or DON to ensure care plans are revised and	

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F 657	Continued From page 8 admitted to the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1 [redacted] Review of R74 's admission "MDS" with an assessment reference date (ARD) of NJ ex order 26.4b1 revealed R74 was NJ Exec. Order 26:4.b.1 so the BIMS score was NJ Exec. Order 26:4.b.1. The "MDS" indicated that R74 was NJ ex order 26.4b1 [redacted] Review of R74's undated "Order Summary Report" found in the "Order" tab of the EMR revealed R74 was admitted on NJ ex order 26.4b1 [redacted] failure). Keep an NJ ex order 26.4b1 [redacted]." Review of "Physician's Progress Note" found in the "Progress Note" tab of the EMR and dated NJ ex order 26.4b1 revealed, NJ ex order 26.4b1 [redacted] and on the third NJ Exec. Order 26:4.b.1 the Nurse Practitioner (NP) was in the facility and assessed R74 NJ ex order 26.4b1 [redacted] R74's wife and the NP made a decision to ... NJ ex order 26.4b1 [redacted] Review of R74's "care plan" found in the EMR	F 657	updated. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The Director of Nursing or designee will conduct an audit of 5 residents' comprehensive care plans of residents who had a fall with injury once a week for one month, then bi-weekly for two months, and then quarterly. - The Director of Nursing will present the results of the audit to the Quality Assurance Committee for review and determine the need for further performance improvement.	

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F 657	Continued From page 9 under the "Care Plan" tab revealed there was no documentation in the care plan to accurately reflect R74's NJ ex order 26.4b1, or changes in his care related to his NJ Exec. Order 26:4.b.1 status at all. Interview on 01/25/24 at 3:50 PM, the MDS Coordinator confirmed that R74's care plan should have been updated immediately when R74 NJ ex order 26.4b1	F 657		
F 686 SS=G	NJAC 8:39-11.2(h) Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the facility failed to ensure that a resident who entered the facility without a NJ Exec. Order 26:4.b.1 received care and services to prevent the development of NJ Exec. Order 26:4.b.1 for one (Resident (R) 68) of three residents reviewed	F 686	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #68 NJ ex order 26.4b1 and	2/8/24

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F 686	Continued From page 10 for NJ ex order 26.4b1 in a total sample of 28. This failure caused R68 to develop an NJ ex order 26.4b1 . Additionally, after the NJ ex order 26.4b1 , the facility staff failed to turn and reposition two of three residents (R68 and R17) and failed to use a NJ Exec. Order 26:4.b.1 as ordered to NJ Exec. Order 26:4.b.1 of R68's NJ ex order 26.4b1 . Findings include: Review of R68's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed an admission date of NJ ex order 26.4b1 with NJ ex order 26.4b1 . Review of R68's admission "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 , revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of NJ ex out of 15, indicating R68 NJ ex order 26.4b1 . The "MDS" indicated R68 did not have any NJ ex order 26.4b1 During an interview on 01/23/24 at 12:11 PM, R68 stated that he NJ ex order 26.4b1 R68 stated that staff never repositioned him. R68 stated and demonstrated that he holds onto the bilateral siderails and attempts to lift himself up to NJ Exec. Order 26:4.b.1 . R68 was observed to have a regular mattress. Review of R68's 'NJ Exec. Order 26:4.b.1	F 686	was put on turning and repositioning every two hours as tolerated. - Resident #74 was put on regular turning and repositioning every two hours as tolerated. - Resident #17 care plan was updated to reflect current NJ Exec. Order 26:4.b.1 and care and treatment provided. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by this practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/26/2024, the DON conducted an audit on the on all residents with wounds/pressure ulcers, and at high risk of developing wounds/pressure ulcers, and ensured all residents are on low air-loss pressure relieving mattress. - On 1/26/2024, the DON and designee reviewed the task assignment sheets of all residents with wounds/pressure ulcers and at high risk of developing wounds/pressure ulcers, and ensured turning and repositioning every two hours as tolerated are done. - The DON and designee provided in-services to the nursing staff and certified nursing assistants about the facility's policy on pressure ulcer prevention. The education and in-service included wound consult	

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F 686	Continued From page 11 NJ Exec. Order 26:4.b.1," located in the EMR under the "Forms" tab, dated NJ ex order 26.4b1 indicated that R68 was at a NJ ex order 26.4b1 Review of R68's physician's "Initial Evaluation/Consultation," dated 1 NJ ex order 26.4, provided by the facility, indicated a physical exam showed R68's skin had NJ ex order 26.4b1 Review of R68's "Wound Care Notes," located in the EMR under the "Misc (Miscellaneous)," tab, dated NJ ex order 26.4b1, indicated R68 had an NJ ex order 26.4b1 " and with orders which indicated, "Reposition side to side ... Recommend NJ Exec. Order 26:4.b.1." Review of R68's NJ Exec. Order 26:4.b.1 Notes," located in the EMR under the "Misc," tab, dated NJ ex order 26.4b1, indicated R68 had an NJ ex order 26.4b1 . NJ ex order 26.4b1 and with orders which indicated, "Reposition side to side ... Recommend NJ Exec. Order 26:4.b.1." Review of R68's "Order Summary," located in the EMR under the "Orders" tab revealed an order dated NJ ex order 26.4b1 NJ ex order 26.4b1 This order was discontinued on NJ ex order 26.4b1. A new order dated NJ ex order 26.4b1 indicated, "NJ ex order 26.4b1 Reposition side	F 686	reports and comprehensive care plan reviews to ensure orders/recommendations from wound physicians are carried out and reflected in residents' care plans. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The Director of Nursing or designee will review weekly wound reports to ensure orders and recommendation are implemented and reflected in the residents' care plans. - The Director of Nursing or designee will conduct an audit of all residents with wounds/pressure ulcers to ensure they are on low air loss pressure relieving mattress weekly X 4 weeks, and then every two weeks X 8 weeks. - The Director of Nursing will present the results of the audit to the Quality Assurance Committee for review and determine the need for further performance improvement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315511	A. BUILDING _____ B. WING _____	C 01/27/2024

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F 686	Continued From page 12	F 686		

to side." This order was discontinued on NJ ex order 26.4b1, then an order was obtained on NJ ex order 26.4b1 indicated NJ ex order 26.4b1 [redacted]."

During a continuous observation from 01/24/24 at 8:45 AM through 01/24/24 at 11:51 AM, R68 remained lying on his back. R68 was not repositioned by facility staff during this continuous observation.

Review of R68's "Physician's Progress Note," dated NJ ex order 26.4b1, located in the EMR under the "Progress Notes" tab revealed, "PT [patient] NJ ex ord [redacted]"

During an interview on 01/25/24 at 9:11 AM, Licensed Practical Nurse (LPN)1 confirmed R68 was on a regular mattress.

During an interview on 01/25/24 at 9:15 AM, Certified Nursing Assistant (CNA)2 stated she discovered what she believed to be a NJ ex order 26.4b1" on R68's NJ ex order 26.4b1. CNA2 further stated that R68 should be repositioned every two hours. CNA2 stated that R68 NJ ex order 26.4b1 [redacted]

During an interview on 01/25/24 at 11:36 AM, the R68's physician stated he saw R68 approximately three weeks ago. The physician stated the NJ ex order 26.4b1 [redacted] he physician stated that R68 should be repositioned every two hours and should be on a NJ Exec. Order 26:4.b.1. The Physician stated, NJ ex order 26.4b1 [redacted] these things need

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F 686	Continued From page 13 to be implemented immediately." During an interview on 01/25/24 at 11:50 AM, the NJ Exec. Order 26:4.b.1 Doctor stated that she ordered R68 NJ ex order 26.4b1 . The NJ Exec. Order 26:4.b.1 Doctor stated an alternative to an air mattress would be a NJ ex order 26.4b1 , which would also have to be moved every two hours. The Wound Care Doctor stated she expected the resident to be repositioned, NJ Exec. Order 26:4.b.1, and for the resident to be on a NJ Exec. Order 26:4.b.1. During an interview on 01/25/24 at 1:13 PM, the Director of Nursing (DON) stated that R68 should be repositioned every two hours and that R68 was NJ Exec. Order 26:4.b.1 . The DON confirmed that R68 was not on NJ Exec. Order 26:4.b.1 The DON stated that the mattresses had been ordered but had not arrived. 2. Observation on 01/24/24 at 8:40AM revealed R17 positioned on her back with the head of bed (HOB) elevated 35 degrees. The resident was on NJ Exec. Order 26:4.b.1. Observation on 01/24/24 at 10:10AM, R17 remained in bed positioned on her back with the HOB elevated 25 degrees. Observation on 01/24/24 at 11:00AM, R17 remained positioned on her back with the HOB elevated 35 degrees. Observation on 01/25/24 at 08:10AM, revealed R17 was positioned on her back with HOB elevated 35 degrees.	F 686		

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F 686	Continued From page 14 Observation on 01/25/24 at 11:39 AM, revealed R17 remained positioned on her back with HOB elevated 45 degrees. Observation at this time revealed that the resident had an NJ ex order 26.4b1 [redacted] The resident had a NJ ex order 26.4b1 [redacted] Review of the R17's "Admission Record" located in the EMR "Profile" tab revealed the resident was admitted to the facility on NJ ex order 26.4b1 with diagnoses NJ ex order 26.4b1 [redacted] Review of R17's quarterly MDS" with an ARD of NJ ex order 26.4b1 located in the EMR "MDS" tab revealed the resident had NJ ex order 26.4b1 one NJ ex order 2 [redacted] Review of the quarterly "MDS" with an ARD of NJ ex order 26.4b1 revealed NJ ex order 26.4b1 [redacted] Review of R17's "Care Plan" with a revision date of NJ ex order 26.4b1 located in the EMR "Care Plan" tab revealed interventions for the resident's NJ Exec. O [redacted] n included encourage and assist as needed to turn and reposition; NJ Exec. Order 26:4.b.1; NJ Exec. Order 26:4.b.1; and NJ Exec. Order 26:4.b.1 as needed. Review of R17's "NJ Exec. Order 26:4.b.1 Notes" dated NJ ex order 26.4b1 located in the resident's EMR "Miscellaneous" tab revealed the resident had NJ ex order 26.4b1 [redacted]. In addition to treatment orders the NJ Exec. Order 26:4.b.1 included in the resident's plan of care "The	F 686		

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F 686	Continued From page 15	F 686		

resident and staff were educated on the importance of repositioning and turning."

Review of R17's "Wound Consultant Notes" dated NJ ex order 26.4b1 located in the EMR NJ ex order 26.4b1 The resident NJ ex order 26.4b1 Again, the NJ Exec. Order 26:4.b.1 included in the resident's plan of care that the resident and staff were educated on the importance of repositioning and turning."

Interview on 01/23/24 at 10:30AM, LPN2 revealed R1 NJ ex order 26.4b1 .

Interview on 01/25/24 at 11:39AM, while CNA4 performed incontinent care revealed that she had not repositioned the resident since the start of the shift.

Interview on 01/25/24 at 11:30AM, the NJ Exec. Order 2 Doctor revealed that the NJ ex order 26.4b1 NJ ex order 26.4b1 The NJ Exec. Order 26:4.b.1 Doctor indicated the area identified on assessment as NJ ex order 26.4b1 . The NJ Exec. Order 26:4.b.1 Doctor stated that NJ ex order 26.4b1 At one NJ ex order 26.4b1 The NJ Exec. Order 26:4.b.1 Doctor stated the frequent turning and repositioning R17 had aided

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F 686	Continued From page 16 immensely in the healing process of the resident's [NJ ex order 2] Review of the facility's policy titled "Pressure Injuries Overview" with a revision date of March 2020 reads in part " ...Pressure ulcers/injuries occur as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue ..." NJAC 8:39-27.1(e)	F 686		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:	F 688		2/1/24

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F 688	Continued From page 17 Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident received appropriate treatment and services to prevent a decline in [redacted] for one of two residents (Resident (R) 1) sampled for mobility in a sample of 28 residents. This failure caused the resident to develop a NJ Exec. Order 26:4.b.1. Findings include: During an observation on 01/22/24 at 11:15 AM, 01/23/24 at 12:27 PM, and 01/24/24 at 8:26 AM, R1 was observed to have NJ ex order 26.4b1 and a NJ ex order 26.4b1 . [redacted]. Review of R1's "Admission Record," located in the electronic medical record (EMR) under the "Profile" tab, revealed R1 was admitted to the facility with NJ ex order 26.4b1 [redacted]. Review of R1's quarterly "Minimum Data Set (MDS)," located in EMR under the "MDS" tab with an Assessment Reference Date (ARD) of [redacted] revealed R1's "Brief Interview for Mental Status (BIMS)" score of [redacted] out of 15, indicating R1 was NJ Exec. Order 26:4.b.1 . Review of R1's significant change "MDS" with an ARD of [redacted] revealed a "BIMS" score of [redacted] out of 15, indicating R1 was NJ ex order 26.4b1 [redacted] Both MDSs indicated [redacted]. Review of R1's "Care Plan," located in the EMR under the "Care Plan" tab revealed the absence	F 688	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #1 was immediately evaluated by the Director of Rehabilitation for NJ Exec. Order 26:4.b.1, NJ ex order 26.4b1 [redacted]. - Resident #1 care plan was reviewed and NJ ex order 26.4b1 [redacted] (ADL). 2. How the facility will identify other residents \having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by this practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/24/2024, the Director of Rehabilitation (DOR) conducted an audit on all residents with contracture, decline in mobility or at risk of contracture to evaluate the need for special assistive device such as splint. Included in the audit was residents' functional evaluation and the range of motion. - DON conducted a care plan audit on all residents with contracture, decline in mobility or at risk of contracture to ensure care and services provided such as range of motion exercises are reflected in residents' care plan. - The DON and designee provided	

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F 688	Continued From page 18 of a care plan for NJ Exec. Order 26:4.b.1 [redacted] Review of R1's "Order Summary," located in the EMR under the "Orders" tab revealed the following order dated NJ ex order 26.4b1, "NJ ex order 26.4 [redacted] : NJ ex order 26.4b1 [redacted] " Review of the "Order Summary" located in the EMR revealed no physician orders NJ Exec. Orde after NJ ex order 26.4b1. Review of R1's "Therapy Notes," provided by the facility, indicated that R1 received NJ Exec from NJ ex order 26.4b1. Review of R1's "NJ Exe Discharge Summary," dated NJ ex order 26.4b1 provided by the facility, indicated, "Discharge Recommendations: NJ ex order 26.4b1 [redacted] NJ ex order 26.4b1 [redacted] Recommend NJ ex order 26.4b1 [redacted] in future if patient demos [demonstrates] a decline in functional status ... Prognosis to Maintain CLOF [current level of functioning] = Excellent with consistent staff support." No NJ Exec. Order 26:4.b.1 were noted during this course of treatment. During an interview on 01/24/24 at 2:22 PM, the Director of Rehabilitation (DOR) stated R1 NJ ex ord [redacted]. The DOR stated R1 NJ ex order 26.4b1 and did not know that R1's NJ ex order 26.4b1 [redacted] The DOR stated that R1 NJ ex order 26.4b1 [redacted] During an interview on 01/24/24 at 3:15 PM, OT1 stated R1 NJ ex order 26.4b1. OT1 stated that in NJ ex order 26.4b1, R1 was able to NJ Exec. Order 26:4.b	F 688	in-services to the nursing staff and certified nursing assistants about the facility's policy on restorative nursing, incorporated in the residents' activities of daily living (ADL). 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The Director of Rehabilitation or designee will review occupational therapy services weekly X 4 weeks and then monthly X 2 months. Findings will be reported with the Director of Nursing to ensure all residents at risk for functional decline or contracture are evaluated for occupational therapy services and assistive device such as splint. - The Director of Rehabilitation will perform quarterly functional evaluations of long-term care residents X 4 quarters. - The Director of Rehabilitation will present the results of the audit to the Quality Assurance Committee for review and determine the need for further performance improvement.	

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F 688	Continued From page 19	F 688		

NJ Exec. Or an NJ ex order 26.4b1 .

During an interview on 01/24/24 at 3:30 PM, Family Member (FM) 1 stated that she visited R1 daily until NJ ex order 26.4b1 . FM1 stated at that time, R1's NJ ex order 26.4b1 , but R1 NJ ex order 26.4b1 FM1 stated when she visited on NJ ex order 26.4b1 , R1's NJ ex order 26.4b1 and R1 NJ ex order 26.4b1 FM1 stated that NJ ex order 26.4b1

During an interview on 01/24/24 at 3:40 PM, OT2 stated that she evaluated R1 "a little earlier today" and stated R1 NJ ex order 26.4b1 OT2 NJ ex order 26.4b1 . OT2 confirmed R1's NJ ex order 26.4b1 .

During an interview on 01/25/24 at 2:19 PM, the Director of Nursing (DON) stated she expected a resident with a NJ Exec. Order 26:4.b.1 to have a NJ Exec. Orde , be seen by therapy, or be on a restorative nursing program. The DON reviewed R1's EMR and confirmed that there was no mention of R1's NJ ex order 26.4b1 in the EMR other than the MDS which indicated upper extremity impairment.

During an interview on 01/25/24 at 2:58 PM, Certified Nursing Assistant (CNA)3 confirmed R1 NJ ex order 26.4b1 R1 NJ ex order 26.4b1 CNA3 stated "her [R1] NJ ex order 26.4b1

Review of the facility's policy titled, "Resident Mobility and Range of Motion," revised July 2017, indicated "Residents will not experience an

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F 688	Continued From page 20 avoidable reduction in range of motion (ROM)." NJAC 8:39-27.1(a)(m)	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to thoroughly investigate the NJ ex order 26.4b1 (R)39 and R76) from a sample of 28 residents. R 39 fell and sustained a NJ ex order 26.4b1. The facility failed to investigate the cause of the fall that NJ ex order 26.4b1. Additionally, the facility failed to lock the bed's wheels when transferring R76 back to the bed resulting in R76 NJ ex order 26.4b1 Findings include: 1. Interview on 01/22/24 at 1:10PM, R39's family member (FM2) revealed the NJ ex order 26.4b1 Review of R39's "Admission Record" located in the electronic medical record (EMR) "Profile" tab revealed the resident was admitted to the facility with diagnoses that included NJ ex order 26.4b1	F 689	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #39 NJ Exec was investigated and fall risk care plan was updated. - Resident #76 NJ ex order 26.4b1 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by this practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 01/25/2024, the DON and designee completed an audit of all fall accidents	2/8/24

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	315511	A. BUILDING _____ B. WING _____	C 01/27/2024

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F 689	Continued From page 21 NJ ex order 26.4b1 [redacted]. Review of R39's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) NJ ex order 26.4b1 located in the EMR "MDS" tab revealed the resident was assessed to have Brief Interview for Mental Status (BIMS) score of [redacted] out of 15 indicating the resident had NJ ex order 26.4b1 [redacted] The resident NJ ex order 26.4b1 [redacted] The resident was NJ ex order 26.4b1 [redacted]. Review of R39's Significant Change "MDS" with an ARD of NJ ex order 26.4b1 located in the EMR "MDS" tab revealed the resident's BIMS score was now [redacted] out 15 indicated the resident had NJ ex order 26.4b1 [redacted]. Review of R39's "Fall assessments" located in the resident's EMR "Assessment" tabs revealed a "fall risk assessment" dated NJ ex order 26.4b1, which documented the resident NJ ex order 26.4b1 [redacted] The resident had a score of [redacted] points which indicated the resident NJ ex order 26.4b1. A request was made to the Director of Nursing (DON) for the resident's admission fall risk assessment. The facility was unable to provide an admission fall risk assessment or fall risk assessment after the NJ ex order 26.4b1. Review of R39's "Nurses Notes" dated NJ ex order 26.4b1 located in the EMR "Progress Notes" tab revealed the resident's complaint of NJ ex order 26.4b1; [redacted] and NJ Exec. Order 26:4.b.1; NJ ex order 26.4b1 [redacted] The resident's physician was notified, and	F 689	and incidents in the last 3 months to ensure incident reports are completed, fall care plans are in place, and updates/revisions are reflected in residents' charts. - The DON and clinical team also performed a quality assurance audit and completed education on the following: - Incident reporting and investigation policy and process. - Importance of daily review of incident reports in morning clinical meeting process. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The DON or designee will review the 24-hour report daily to ensure all accident or incident occurrences are reviewed and have been documented in the appropriate accident and incident report. - The DON or designee will review all incident reports daily to ensure that all investigations are completed, and interventions are implemented via the care plan for 1 month, then 1X week for 2 months and then monthly. - The Director of Nursing will present the results of the audit to the Quality Assurance Committee for review and determine the need for further performance improvement.	

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F 689		F 689		

Continued From page 22

NJ ex order 26.4b1. The note failed to document the NJ ex order 26.4b1.

Review of the "Nurses Notes" dated NJ ex order 26.4b1 documented the resident had NJ ex order 26.4b1 and was NJ ex order 26.4b1

Review of R39's "Nurses Notes" dated NJ ex order 26.4b1 located in the EMR "Progress Notes" tab revealed the resident was NJ ex order 26.4b1

Review of R39's "Care Plan" with a revision date of NJ ex order 26.4b1 located in the EMR "Care Plan" tab did not reflect the resident's NJ ex order 26.4b1.

The facility was unable to provide an incident report or an investigation of R39's fall on NJ ex order 26.4b1 which resulted in NJ Exec. Order 26:4.b.1.

Interview on 01/22/24 at 2:00PM, Licensed Practical Nurse (LPN) 2 revealed the resident did NJ Exec. Order 26:4.b.1 sometime NJ Exec. Order 26:. The resident had an episode of NJ ex order 26.4b1 NJ ex order 26.4b1

Interview on 01/25/24 at 2:30PM the DON revealed fall risk assessment are completed on admission, quarterly, annually, 'or as needed. The DON stated incident reports should be completed when a fall or any incident/accident occurs. The DON further stated that this type of incident should be investigated immediately and reported to the Administrator.

Interview on 01/25/24 at 2:30PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315511	A. BUILDING _____ B. WING _____	C 01/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	101 WHIPPANY ROAD WHIPPANY, NJ 07981

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F 689	Continued From page 23	F 689		

Administrator and the Vice President (VP) of Special Clinical Projects, both stated that an incident report and investigation should have been completed for R39's NJ ex order 26.4b1 [redacted]

2. Review of R76's "Admission Record," located in the EMR under the "Profile" tab, revealed an NJ ex order 26.4b1 [redacted]

Review of R76's admission "MDS," located in the EMR under the "MDS" tab with an ARD of NJ ex order 26.4b1, revealed the resident had a "BIMS" score of NJ ex out of 15, indicating R76 was NJ ex order 26.4b1. This same MDS indicated R76's transfer ability was an NJ ex order 26.4b1, with support from two staff. The MDS indicated NJ ex [redacted]

Review of R76's "Progress Note," dated NJ ex order 26.4b1, located in the EMR under the "Progress Notes" tab revealed, " ... nurse was called by the aid [sic] at the patient bedside. Patient was seen sitting up on the ground. As per patient and the aid [sic], while transferring the patient to bed, the bed slipped, and the aid [sic] had to lower the patient on the floor. NJ ex order 26.4b1 [redacted]

Review of R76's "Care Plan," dated NJ ex order 26.4b1, located in the EMR under the "Care Plan" tab, revealed n NJ ex order 26.4b1 [redacted], there were no updates to R76's care plan related to NJ Exec. O

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F 689	Continued From page 24 The facility was unable to provide a [redacted] investigation related to R76's [redacted]. During an interview on 01/25/24 at 6:32 PM, the DON stated that when transferring a resident, the staff should always ensure that the bed is locked. Review of the facility's policy titled "Accidents and Incidents - Investigating and Reporting" dated July 2017 reads in part " ...The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. The charge nurses, supervisor or department director or supervisor shall complete the incident report within 24 hours of the incident. The Director of Nursing shall ensure the Administrator receives a copy of the report form for each occurrence. Incident and accident reports will be reviewed by the Safety Committee for trends related to the hazard hazards in the facility and analyze any individual resident vulnerabilities ..." NJAC 8:39-4.1(a)5	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		2/8/24

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F 695	Continued From page 25 by: Based on interviews and record review the facility failed to update the physician's orders to accurately reflect the [NJ Exec. Order 26:4.b.1] care and services for one resident (R)74 of three residents reviewed for [NJ Exec. Order 26:4.b.1] care and services in the sample of 28 residents.. Findings include: Review of R74's "Face sheet" found in the "Profile" tab of the Electronic Medical Record (EMR) revealed R74 [NJ ex order 26.4b1] with [NJ ex order 26.4b1] Review of R74's admission "Minimum Data Set (MDS)" assessment revealed when [NJ ex order 26.4] R74 [NJ ex order 26.4b1] Review of R74's undated "Order Summary Report" found in the "Order" tab of the EMR revealed R74 was admitted on [NJ ex order 26.4b1] . Keep an extra #8 [NJ ex order 26.4b1] " Review of R74's "Physician's Progress Note" found in the "Progress Note" tab of the EMR and dated [NJ ex order 26.4] revealed, [NJ ex order 26.4b1] (NP) was in the facility and assessed	F 695	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #74 physician orders were reviewed and ensured they are transcribed in the resident□s chart. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by this practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/25/2024, the DON conducted an audit of all residents receiving oxygen to ensure physician orders and services provided are reflected in the residents□ charts. - On 1/25/2024, the DON and ADON provided education to the nursing staff on the facility□s physician order policy. The education included the importance of immediately transcribing physician orders. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The Director of Nursing or designee will conduct an audit of 5 residents□ physician orders once a week for one	

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F 695	Continued From page 26 R74. NJ ex order 26.4b1 [redacted] R74's wife and the NP made a decision to NJ ex order 26.4b1 [redacted] The order changes were implemented as discussed with the wife and documented in the NP's progress notes. R74 NJ ex order 26.4b1 [redacted] Interview on 01/25/24 at 3:30PM, the Administrator stated that physician orders should have been transcribed immediately for R74 to receive proper NJ Exec. Order 26:4.b.1 management. The Administrator was unable to provide a facility policy prior to the survey team exiting the facility.	F 695	month, then bi-weekly for two months, and then quarterly. - The Director of Nursing will present the results of the audit to the Quality Assurance Committee for review and determine the need for further performance improvement.	
F 847 SS=D	NJAC 8:39-23.2(a) Entering into Binding Arbitration Agreements CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(n)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to	F 847		2/8/24

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F 847	Continued From page 27	F 847		

receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n)(2) The facility must ensure that:
(i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands;
(ii) The resident or his or her representative acknowledges that he or she understands the agreement;

§483.70(n)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it.

§483.70(n) (4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

§483.70(n) (5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k).
This REQUIREMENT is not met as evidenced by:

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F 847	Continued From page 28 Based on interview, record review and document review, the facility failed to explain to residents the binding arbitration agreement and failed to inform the resident of the right to rescind the agreement within thirty calendar days for three (Resident (R) 224, R225, and R226) of three residents reviewed for arbitration agreement in a total sample of 28 residents. Findings include: Review of an undated copy of "Admission Agreement," provided to the survey team by the Administrator, with the following, "Dispute Resolution and Arbitration" embedded, indicated, "Any controversy or claim arising out of or relating to this agreement and brought by the resident, his/her personal representative, heirs, attorneys or the responsible party shall be submitted to binding arbitration by a single arbitrator selected and administered pursuant to the commercial arbitration rules of the American Arbitration Association. A claim shall be waived and forever barred if, on the date the demand for arbitration is received, the claim (if asserted in a civil action) would be barred by the applicable state or federal statute of limitations. Any claimant contemplated by this paragraph hereby waives any and all rights to bring such claim or controversy in any manner not expressly set forth in this paragraph including, but not limited to, the right to a jury trial." During an interview on 01/25/24 at 4:46 PM, the Social Worker (SW) stated that the arbitration agreement was a part of the "Admission Agreement." The SW stated when she explained arbitration agreements to the residents, she would tell them that if they had any issues with	F 847	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #224 , Resident #225, Resident #226 The Administrator immediately reviewed the facility process of communicating the arbitration agreement with the patients and/or responsible parties. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by this practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/25/2024, the Administrator and designee provided an education to the social worker on the importance of communicating the arbitration agreement with the residents and/or their responsible parties in a language that is easy to understand. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The Director of Social Services/Admissions Director or designee will conduct an audit of 5 residents' or responsible party's understanding of the	

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F 847	Continued From page 29 the facility, they could reach out to the Administrator. Additionally, the SW stated she told the residents that they have a right to a jury trial. The SW was unable to state if the residents understood the binding arbitration agreement. The SW stated that she would sometimes leave a copy of the completed "Admission Agreement" with the resident to read in their own time. During an interview on 01/25/24 at 5:36 PM, the Administrator stated the SSD was responsible for the arbitration agreements. Review of the "Dispute Resolution and Arbitration" which was embedded within the "Admission Agreement" document revealed the absence of the resident's right to rescind the agreement within thirty calendar days. 1. Review of R225's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R225 NJ ex order 26.4b1 [redacted] Review of R225's admission "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of NJ ex order 26.4b1 [redacted], revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of NJ ex [redacted] out of 15, indicating R225 was NJ ex order 26.4b1 [redacted] Review of R225's "Admission Agreement," provided by the Administrator, revealed R225 signed the arbitration agreement upon admission. Review of the "Dispute Resolution and Arbitration " revealed the absence of the resident's right to rescind the agreement within thirty calendar days.	F 847	arbitration agreement once a week for one month, then bi-monthly for two months, and then quarterly. - The DOSS and AD will present the results of the audit to the Quality Assurance Committee for review and determine the need for further performance improvement.	

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F 847	Continued From page 30 During an interview on 01/25/24 at 6:23 PM, R225 confirmed his signature on the "Dispute Resolution and Arbitration" portion of the "Admission Agreement." R225 stated that he may have previously heard of arbitration agreements. R225 stated the facility did not explain the binding arbitration agreement. 2. Review of R224's "Admission Record," located under the "Profile" tab of the EMR, revealed R224 was admitted on NJ ex order 26.4b1 Review of R224's admission "MDS," located in the EMR under the "MDS" tab with an ARD of NJ ex order 26.4b1, revealed the resident had a "BIMS" score of NJ ex out of 15, indicating R224 was NJ ex order 26.4b1 Review of R224's "Admission Agreement," provided by the Administrator, revealed R224 signed the arbitration agreement upon admission. Review of the "Dispute Resolution and Arbitration " revealed the absence of the resident's right to rescind the agreement within thirty calendar days. During an interview on 01/25/24 at 6:25 PM, R224 confirmed his signature on the "Dispute Resolution and Arbitration" portion of the "Admission Agreement." R224 stated he was unaware of the meaning of a binding arbitration agreement and that the facility did not explain the binding arbitration agreement. 3. Review of R226's "Admission Record," located under the "Profile" tab of the EMR, revealed R226 was admitted on NJ ex order 26.4b1. Review of R226's admission "MDS," located in	F 847		

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F 847	Continued From page 31 the EMR under the "MDS" tab with an ARD of [redacted], revealed the resident had a "BIMS" score of [redacted] out of 15, indicating R226 [redacted] Review of R226's "Admission Agreement," provided by the Administrator, revealed R226 [redacted] Review of the "Dispute Resolution and Arbitration " revealed the absence of the resident's right to rescind the agreement within thirty calendar days. During an interview on 01/25/24 at 6:27 PM, R226 confirmed his signature on the [redacted]" portion of the [redacted]." R226 stated he was unaware of the meaning of a binding arbitration agreement and that the facility did not explain the binding arbitration agreement. During an interview on 01/25/24 at 6:31 PM, the Administrator stated the facility did not have an arbitration policy. NJAC 8:39-4.1(a)8 NJAC 8:39-13.1(a)	F 847		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		2/28/24

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F 880	Continued From page 32 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 33 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review and review of manufacturer's instruction, the facility failed to sanitize the NJ Exec. Order 26:4.b.1 that were used for more than one resident, before and after each resident's use. The facility failed to properly sanitize the NJ Exec. Order 26:4.b.1 used on three (Resident (R)124, R17 and R36) residents from a sample of 28 residents. On 01/24/24 at 8:01 PM, the Administrator and Director of Nursing (DON) were notified that an Immediate Jeopardy existed at F880-J Infection Control due to the failure to sanitize multi-use NJ Exec. Order 26:4.b.1 between residents per manufacturer's instructions. The facility provided an acceptable Removal Plan which included retraining and ensuring	F 880	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Resident #124, Resident #17, Resident #36. NJ ex order 26.4b1 hat was sanitized by LPN #1 with 70% alcohol wipes was re-sanitized using the microkill wipes. - LPN #1 was provided an immediate education and clinical practice referral related to NJ Exec. Order 26:4.b.1 policy and processes. No residents were identified as being negatively impacted by this practice. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be	

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F 880	Continued From page 34 competency of all Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) on the use and sanitization of glucometers. The nurses were trained on the facility's policy and manufacturer's instructions. Through interviews with facility staff, observations of glucose testing, and review of staff in-services, the survey team verified implementation and removed the Immediate Jeopardy on 01/25/24 at 6:36 PM. The deficient practice remained at a scope and severity of D (isolated for more than minimal harm) following the removal of the immediate jeopardy. Findings include: Review of R124' s "Admission Record" located in the electronic medical records (EMR) "Profile" tab revealed the resident was admitted to the facility with diagnoses that included NJ ex order 26.4b1 [redacted] Review of R124's "Physicians Orders" for NJ ex order 26.4b1 located in the EMR "Orders" tab revealed the resident NJ ex order 26.4b1 [redacted]. Review of the R124's "Medication Administration Record (MAR)" for NJ Exec. Order 26:4.b.1 located in the EMR "Orders" tab revealed the resident received at NJ Exec. Order 26:4.b.1 at 7:30AM and 11:30AM performed by LPN1. Review of R17's "Admission Record" located in the EMR "Profile" tab revealed the resident was admitted to the facility with a diagnosis of NJ ex order 26.4b1	F 880	affected by this practice. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/24/2024, the DON immediately conducted an audit of all residents who had glucometer testing in the facility. Residents were audited for potential exposure to blood borne pathogens. No residents were identified as being negatively impacted by this practice. - On 1/24/24, all residents in the facility requiring blood glucose monitoring were reviewed by DON and Vice President of Clinical Special Projects. Two glucometers on each med cart were provided, eight in total, and were cleaned to ensure the equipment was disinfected according to policy between resident use. - On 1/24/2024, the Director of Nursing provided an education to all nurses on the facility□s policy on blood glucose monitoring. Education included review of products for this procedure, contact time, and all infection prevention and control requirements. - On 1/24/2024, the Director of Nursing and designee completed a competency evaluation on LPN #1 and all nurses on blood glucose monitoring achieving 100% competency compliance for nursing staff. - Newly hired nurses will be trained in orientation and demonstrate competence with blood glucose monitoring and infection control procedures prior to independent practice.	

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	315511	A. BUILDING _____ B. WING _____	C 01/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	101 WHIPPANY ROAD WHIPPANY, NJ 07981

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F 880	Continued From page 35 Review of R17's "Vital Record" located in the resident's EMR "MAR" tab revealed that LPN1 performed R17's NJ ex order 26.4b1 at 08:10AM and 12:23PM. Review of R36's "Admission Record" located in the EMR "Profile" tab revealed the resident was admitted with diagnosis that included NJ ex order 26.4b1 [redacted] Review of R36's "Vitals Record" located in the EMR "MAR" tab revealed that LPN1 performed R36's NJ ex order 26.4b1 at 7:58AM and 12:20PM. Observation during the medication administration on 01/24/24 at 9:03AM, revealed LPN1 preparing to perform R124's NJ Exec. Order 26:4.b.1. LPN1 gathered the materials to perform the NJ Exec. Order 26:4.b.1 and entered the resident's room. The nurse wiped the NJ Exec. Order 26:4.b.1 with an alcohol wipe front and back and then performed the NJ Exec. Order 26:4.b.1. LPN1 removed the NJ Exec. Order 26:4.b.1 materials from the resident's room. LPN1 wiped the NJ Exec. Order 26:4.b.1 with an alcohol wipe. Interview 01/24/24 at 9:30AM, LPN1 stated that there was only one NJ Exec. Order 26:4.b.1 on the medication cart. The NJ ex order 26.4b1 had been used on two other residents (R17 and R36) before using it for R124. LPN1 stated that she had been trained to sanitize the NJ Exec. Order 26:4.b.1 with alcohol wipes. Interview on 01/24/24 at 11:40AM, LPN2 stated that the medication carts always keep two glucometers. LPN2 stated that she had been trained to sanitize the glucometers before and after each resident's use with germicidal agent Micro Kill One.	F 880	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The Director of Nursing and Assistant Director of Nursing will conduct audits to monitor nurses performing blood glucose monitoring, including the procedure for cleaning the glucometer between patients daily x 5 days, then twice weekly for 2 weeks, weekly x 4 weeks, and monthly x 3 months and reporting to the QAPI committee quarterly. On□going. - The Director of Nursing will present the results of the audit to the Quality Assurance Committee for review and determine the need for further performance improvement. DPOC - QIO - submitted 2/27/24 RCA - submitted 2/28/24 Both via e-mail to DOH	

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F 880	Continued From page 36	F 880		

Review of the facility's policy titled "Blood Glucose Monitoring" dated 2012 indicated, "Disinfect the glucometer before and after each resident use or when the monitor is visibly soiled. Use Super Sani Cloths Germicidal Disposable Wipes (or other commercially prepared pre-moistened wipes which meet the CDC [Center for Disease Control] guidelines to wipe down the meter. If blood is visible present, then a second Sani-Cloth germicidal disposable wipe must be used ..."

Review of the glucometer's manufacturer's instructions for EVENCARE G3 Meter revealed "The EVENCARE G3 Meter should be cleaned and disinfected between each patient. The meter is validated to withstand a cleaning and disinfection cycle of ten times a day for an average period of three years. The following products have been approved for cleaning and disinfecting the EVENCARE G3 Meter: Dispatch Hospital Disinfectant Towels with Bleach; Medline Micro Kill One Disinfecting, Cleaning Wipes with Alcohol; Clorox Healthcare Bleach Germicidal and Disinfectant Wipes; and Medline Micro Kill One Bleach Germicidal Bleach Wipes."

Review of the Micro Kill One manufacturer's instructions revealed, " ...use one or more wipes as necessary to wet surface sufficiently and thoroughly clean the surface. The treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed on this label. Micro Kill One Germicidal Alcohol Wipes are an effective virucide, bactericide, tuberculocidal, and fungicide against hepatitis b virus, hepatitis c virus, norovirus, HIV [human immunodeficiency virus, a retrovirus which causes AIDS] + virus, influenza virus, E coli

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F 880	Continued From page 37 [Escherichia coli] virus, pseudomonas virus, salmonella virus, staphylococcus aureus, vancomycin resistant enterococcus, methicillin resistant staphylococcus aureus." Review of the facility's "inservice education records" dated 11/29/23 revealed staff education was provided on sanitizing the glucometers according to the facility policy. Review of the attendance sheet revealed LPN1 attended this training session. The facility currently has three residents with NJ ex order 26.4b1 however, only one (R125) of the three residents required NJ Exec. Order 26:4.b.1 NJ ex order 26.4b1. R125 was admitted with diagnosis of (NJ ex order 26.4b1 Interview on 01/24/24 at 3:00PM, the Director of Nursing (DON) stated that it was her expectation that the glucometers would be sanitized according to the facility policy. Glucometers were to be sanitized before and after each resident's use. NJAC 8:39-19.4(1)	F 880		

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S 000	Initial Comments The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficieny and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The facility leadership team has met on an ongoing basis and continued to identify staffing challenges and areas of improvement for licenses and certified staffing needs. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected by this practice.	2/8/24

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

Electronically Signed | 02/12/24

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S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the 4 weeks of Complaint staffing from 01/30/2022 to 02/26/2022, the facility was deficient in CNA staffing for residents on 2 of 23 day shifts as follows: -01/30/22 had 10 CNAs for 88 residents on the day shift, required at least 11 CNAs. -02/06/22 had 9 CNAs for 82 residents on the day shift, required at least 10 CNAs. 2. For the 2 weeks of Complaint staffing from 04/10/2022 to 04/23/2022, the facility was deficient in CNA staffing for residents on 1 of 14 day shifts as follows: -04/21/22 had 5 CNAs for 49 residents on the day shift, required at least 6 CNAs. 3. For the 3 weeks of Complaint staffing from 06/19/2022 to 07/09/2022, the facility was deficient in CNA staffing for residents on 5 of 21 day shifts as follows:	S 560	3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - The DON conducted an audit of staffing schedules with the current facility census to ensure fulfillment of staffing requirements per shift. - The facility has implemented an incentive program including referral bonuses for employees referring staff where appropriate, conducted job fairs, immediate interviews with contingency offers and expedited the onboarding process of new hires. - The facility has contracted a vendor with agency staff as needed to meet staffing needs. - The Director of Nursing and Director of Rehabilitation continue to partner in addressing staffing challenges. Where appropriate, the occupational therapy staff assist in providing care and activities of daily living to residents. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The DON and/or designee will meet with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. - The DON and/or designee will monitor callouts and staffing ratios weekly until the requirement is met. - The results of the audits will be	

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S 560	Continued From page 2 -06/29/22 had 5 CNAs for 51 residents on the day shift, required at least 6 CNAs. -06/30/22 had 5 CNAs for 52 residents on the day shift, required at least 6 CNAs. -07/05/22 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -07/06/22 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -07/09/22 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. 4. For the 3 weeks of Complaint staffing from 08/14/2022 to 09/03/2022, the facility was deficient in CNA staffing for residents on 3 of 21 day shifts as follows: -08/26/22 had 5 CNAs for 45 residents on the day shift, required at least 6 CNAs. -08/27/22 had 5 CNAs for 47 residents on the day shift, required at least 6 CNAs. -08/28/22 had 5 CNAs for 46 residents on the day shift, required at least 6 CNAs. 5. For the 2 weeks of Complaint staffing from 10/02/2022 to 10/15/2022, the facility was deficient in CNA staffing for residents on 10 of 14 day shifts as follows: -10/02/22 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/03/22 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/05/22 had 6 CNAs for 53 residents on the day shift, required at least 7 CNAs. -10/07/22 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -10/09/22 had 6 CNAs for 56 residents on the day shift, required at least 7 CNAs. -10/10/22 had 6 CNAs for 55 residents on the day	S 560	forwarded to the facility Administrator and QAPI Committee for further review and recommendations as needed.	

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S 560	Continued From page 3 shift, required at least 7 CNAs. -10/11/22 had 6 CNAs for 55 residents on the day shift, required at least 7 CNAs. -10/12/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -10/13/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. -10/14/22 had 6 CNAs for 54 residents on the day shift, required at least 7 CNAs. 6. For the 2 weeks of staffing prior to survey from 01/07/2024 to 01/20/2024, the facility was deficient in CNA staffing for residents on 11 of 14 day shifts as follows: -01/07/24 had 7 CNAs for 81 residents on the day shift, required at least 10 CNAs. -01/08/24 had 6 CNAs for 81 residents on the day shift, required at least 10 CNAs. -01/10/24 had 6 CNAs for 81 residents on the day shift, required at least 10 CNAs. -01/11/24 had 9 CNAs for 81 residents on the day shift, required at least 10 CNAs. -01/12/24 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs. -01/13/24 had 8 CNAs for 81 residents on the day shift, required at least 10 CNAs. -01/14/24 had 7 CNAs for 81 residents on the day shift, required at least 10 CNAs. -01/15/24 had 7 CNAs for 81 residents on the day shift, required at least 10 CNAs. -01/16/24 had 7 CNAs for 80 residents on the day shift, required at least 10 CNAs. -01/17/24 had 8 CNAs for 80 residents on the day shift, required at least 10 CNAs. -01/19/24 had 9 CNAs for 80 residents on the day shift, required at least 10 CNAs.	S 560		

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{F 000}	INITIAL COMMENTS An onsite revisit was conducted on 03/14/2024 to verify the facility's Plan of Correction associated with the 01/27/2024 Recertification survey. The facility was found to be in compliance with 42 CFR Part 483, Subpart B for Long Term Care Facilities.	{F 000}		

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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.

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{S 000}	Initial Comments An onsite revisit was conducted on 03/14/2024 to verify the facility's Plan of Correction associated with the 01/27/2024 Re-licensure survey. The facility was not in compliance with the standards in the New Jersey Administrative code, 8:39, standards for licensure of Long Term Care Facilities. The facility must submit a Plan of Correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the provisions of the New Jersey Administrative Code, Title 8, chapter 43E, enforcement of licensure regulations.	{S 000}		
{S 560}	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on 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. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for	{S 560}	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - The facility leadership team has met on an ongoing basis and continued to identify staffing challenges and areas of improvement for licenses and certified staffing needs. How the facility will identify other residents having the potential to be affected by the	3/22/24

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{S 560}	Continued From page 1 nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. For the 2 weeks of staffing from 02/25/2024 to 03/09/2024 for the 03/14/2024 Revisit survey, the facility was deficient in CNA staffing for residents on 13 of 14 day shifts as follows: -02/25/24 had 7 CNAs for 85 residents on the day shift, required at least 11 CNAs, -02/26/24 had 8 CNAs for 85 residents on the day shift, required at least 11 CNAs. -02/27/24 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -02/28/24 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs. -02/29/24 had 9 CNAs for 83 residents on the day shift, required at least 10 CNAs. -03/01/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -03/02/24 had 9 CNAs for 83 residents on	{S 560}	same deficient practice. - All residents have the potential to be affected by this practice. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - The DON conducted an audit of staffing schedules with the current facility census to ensure fulfillment of staffing requirements per shift. - A market analysis was conducted and the center will implement a rate adjustment for license and certified nursing staff. - The facility has implemented an incentive program including referral bonuses for employees referring staff where appropriate, conducted job fairs 3/11-3/22/2024, and immediate interviews with contingency offers. - The facility implemented an expedited and robust onboarding process for new hires. Weekly orientation is in place and as needed. - The facility has contracted vendors with agency staff as needed to meet staffing needs. The facility contracted with Intely and ATC to schedule CNAs daily as needed to meet state staffing requirement. - The Director of Nursing and Director of Rehabilitation continue to partner in addressing staffing challenges. Where appropriate, the occupational therapy staff assist in providing care and activities of daily living to residents. - Facility will also use physical and occupational therapy to assist with morning activity of daily living. - The facility continues to offer free	

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CAREONE AT HANOVER TOWNSHIP	101 WHIPPANY ROAD WHIPPANY, NJ 07981

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{S 560}	Continued From page 2 the day shift, required at least 10 CNAs. -03/03/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -03/04/24 had 7 CNAs for 83 residents on the day shift, required at least 10 CNAs. -03/06/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -03/07/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -03/08/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs. -03/09/24 had 8 CNAs for 83 residents on the day shift, required at least 10 CNAs.	{S 560}	attendance at their Certified Nursing Assistant training program offered non-stop throughout the year. Three current employees (two from recreation, one from administration) are enrolled in the program. - The facility continues to utilize social media, employment sites, and recruitment efforts to hire new staff members. There had been four new CNA hires and seven newly hired nurses. - Facility will continue to admit new patients due to the high demand needs of the hospital and community, and will continue to use all hands approach with both clinical and non-clinical team to assist with patient. Patient concierge program is in place by clinical and non-clinical staff. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The DON and/or designee will meet with the staffing coordinator daily to review facility census, call outs if any, and staffing needs. - The DON and/or designee will monitor callouts and staffing ratios weekly until the requirement is met. - The results of the audits will be forwarded to the facility Administrator and QAPI Committee for further review and recommendations as needed	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
14004		4/2/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	101 WHIPPANY ROAD WHIPPANY, NJ 07981

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 03/22/2024	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	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 1/27/2024	☐ 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
	315511	A. BUILDING **01, 02** B. WING _____	**01/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	**101 WHIPPANY ROAD** **WHIPPANY, NJ 07981**

(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 An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health on 01/27/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field Operations on 01/27/24 and was found to be in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The first building labeled the Mansion was constructed in 1890 as a residence and was later used as a nursing home. The building is three stories and constructed of a wood frame The building construction is classified as Type V (000) with three smoke zones. There is a two-hour fire wall between the existing skilled nursing facility and the Mansion. The building is used for administrative offices (Floor 2), rehabilitation therapy and the lobby (Floor 1) and a below grade basement housing support/mechanical areas.	K 000		
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Health Care Management Solutions LLC on behalf of the New Jersey Department of Health (NJDOH), Health Facility Survey and Field	K 000		

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

Electronically Signed | 02/14/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315511	A. BUILDING **01, 02** B. WING _____	**01/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	**101 WHIPPANY ROAD** **WHIPPANY, NJ 07981**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Operations on 01/27/24 and was found to be not in compliance with requirements for participation in Medicare/Medicaid at 42 CFR 483.90 (A) Life Safety from fire and the 2012 edition of the National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), chapter 19 EXISTING health care occupancy. The Residential (second) building was completed in 2010. The building is two stories with concrete flooring and roofing, and block bearing walls with fire resistive coatings on all exposed steel. The building type is classified as Type II (111). An assisted living building constructed in 2022 is connected to the skilled nursing facility and separated by two-hour fire walls on each of the two floors. The facility has a 525-kilowatt (KW) diesel generator that tests under a load at 57% of capacity. The facility has seven smoke compartments and a census of 82.	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		2/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315511	A. BUILDING **01, 02** B. WING _____	**01/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	**101 WHIPPANY ROAD** **WHIPPANY, NJ 07981**

(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 324	Continued From page 2 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the kitchen hood system was Underwriters Laboratories (UL)300 compliant in accordance with NFPA 96 (2011 edition) section 10.6.2. This deficient practice had the potential to affect all 82 residents in the building. Findings include: An observation on 01/27/24 at 10:45 AM of the kitchen hood pull station for the suppression system revealed the kitchen hood extinguishment system covered all appliances and was equipped with a manual pull station near the exit to the main kitchen. Review of facility's two most recent kitchen hood inspection reports (dates not readable -possibly 9/18/23 and 3/22/23) titled, "Kitchen System Report," indicated at item #31 "did the alarm system activate when the system was tripped." The answer was not applicable or "n/a." The report also indicated a hydrostatic test was to be performed in 2024.	K 324	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. - Kitchen hood inspection was not current, and Kitchen Pull Station # 31 did not alarm system activate when the system was tripped. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. - All residents have the potential to be affected. 3. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. - On 1/27/2024, the Regional Director of Environmental Services was educated on the requirement of kitchen hood pull station suppression system. - On 2/13/2024, The Regional Director of Environmental Services and designee contacted Johnson Control, work order was issued and completed. All Kitchen	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315511	A. BUILDING **01, 02** B. WING _____	**01/27/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	**101 WHIPPANY ROAD** **WHIPPANY, NJ 07981**

(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 324	Continued From page 3 During an interview on 01/27/24 at 2:00 PM, the Regional Director of Environmental Services indicated he was not aware of the requirement and would correct it. He also stated some earlier reports from 2019 indicated the kitchen hood system was connected to the fire alarm system. NJAC 8:39-31.1(c), 31.2(e) NFPA 96	K 324	hood inspection are also current/up-to-date. - The Maintenance Director was educated on the importance of kitchen hood inspection and legibility of label once inspected. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. - The Maintenance Director or designee will perform quarterly inspection X 2 quarters and then annually to ensure continued compliance. - The results of the rounds/audit will be presented to the Quality Assurance Committee quarterly. - The Quality Assurance Committee will determine the need for further performance improvement. Work Order Commpleted and Submitted via e-mail 2/22/24. Unable to attach PDF	

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)
315511	A. Building 02 - RESIDENTIAL B. Wing	3/14/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREONE AT HANOVER TOWNSHIP	101 WHIPPANY ROAD WHIPPANY, NJ 07981

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0324	Correction Completed 02/13/2024	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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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 1/27/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			